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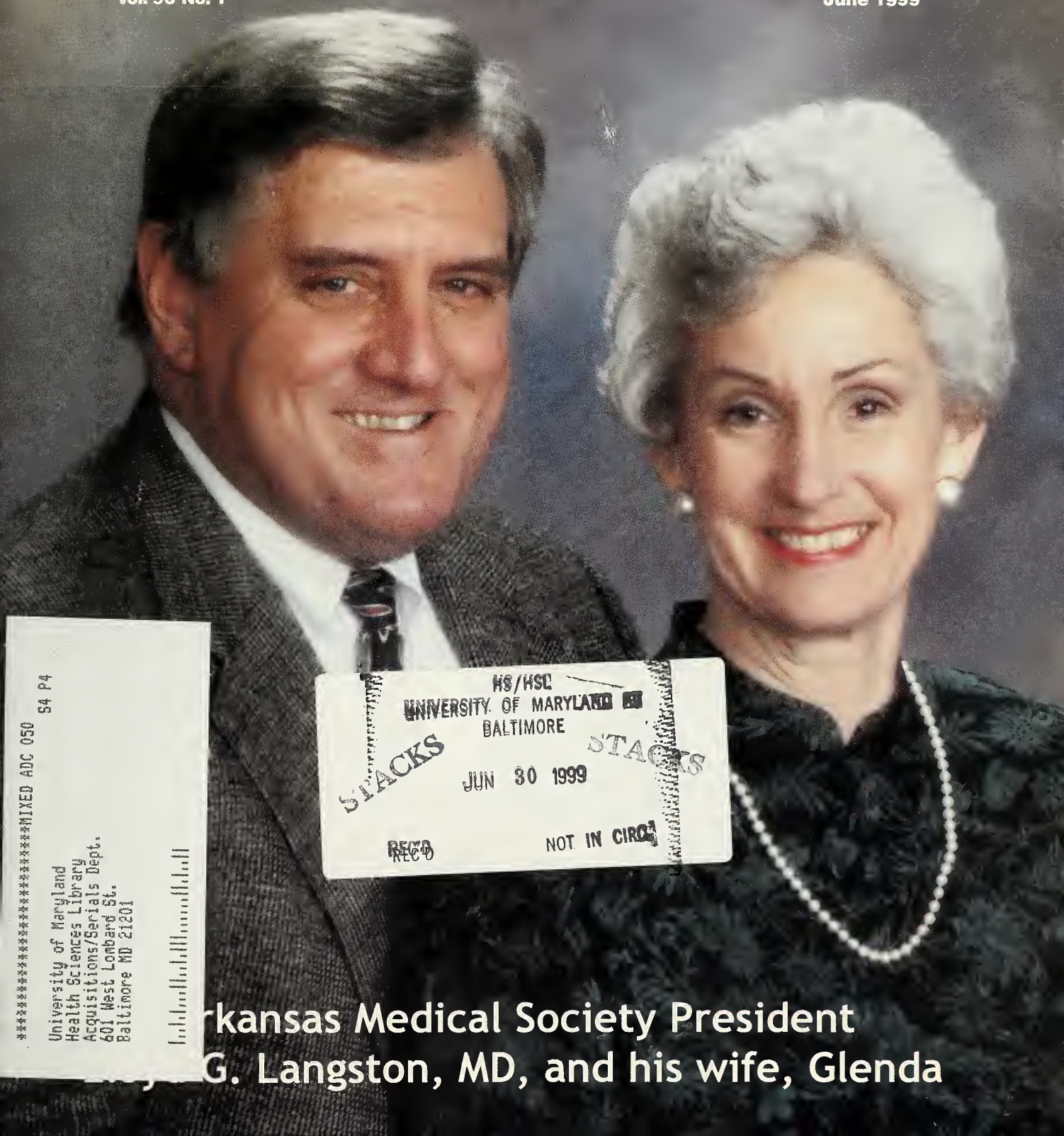
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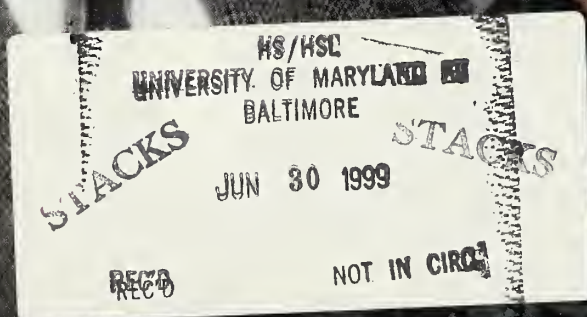
OF THE ARKANSAS MEDICAL SOCIETY

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Arkansas Medical Society President
G. Langston, MD, and his wife, Glenda

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THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Award-Winning Journal of the Arkansas Medical Society
Annual Session Special Issue

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IN + THE + NEWS

Medical board at the top

The Arkansas State Medical Board ranks fourth among state medical boards as the best in disciplining physicians who fail to follow specific state regulations, according to a report released in April by the Public Citizen's Health Research Group.

In 1998, the Arkansas State Medical Board handed down 8.32 actions per 1,000 physicians, according to the report, based on data from the Federation of State Medical Boards. Actions include license revocations, surrenders, suspensions and probation/restrictions.

The other top state medical boards included Alaska, 15.4 actions per 1,000 physicians, Oklahoma, 9.23 actions, Mississippi, 8.92 actions, and West Virginia, 7.68 actions. States most lenient on problem physicians were Massachusetts, Missouri, Florida, Delaware and Tennessee.

Officials with Public Citizen say the report raises serious questions about how well patients in states with poor disciplinary rates are being protected from physicians who might be barred from practicing in states with more active medical boards.

The full text of the report is available at Public Citizen's web site at www.publiccitizen.org.

Hospital charges less than average

Average costs for patients who are admitted to Arkansas hospitals for diagnostic work, treatment and surgery continue to be less than charges in the country's other hospitals, according to a report in the 1999 edition of the American Hospital Association's *Hospital Statistics*.

The average bill for a hospitalized patient in Arkansas was \$9,504 in 1997, the most recent year information is available. That compares with a national average of



\$12,054 and \$11,808 for hospitals in the West South Central region of the country — which includes Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

Arkansas ranked 41 among the 50 states and the District of Columbia in charges per stay. Washington, D.C. posted the highest charges (\$18,815), followed by Hawaii (\$15,933), Nevada (\$15,684), California (\$14,817) and Alaska (\$14,663). The least expensive hospital stays were in Mississippi, Iowa, Idaho, Wyoming and Maryland.

Arkansas hospitals

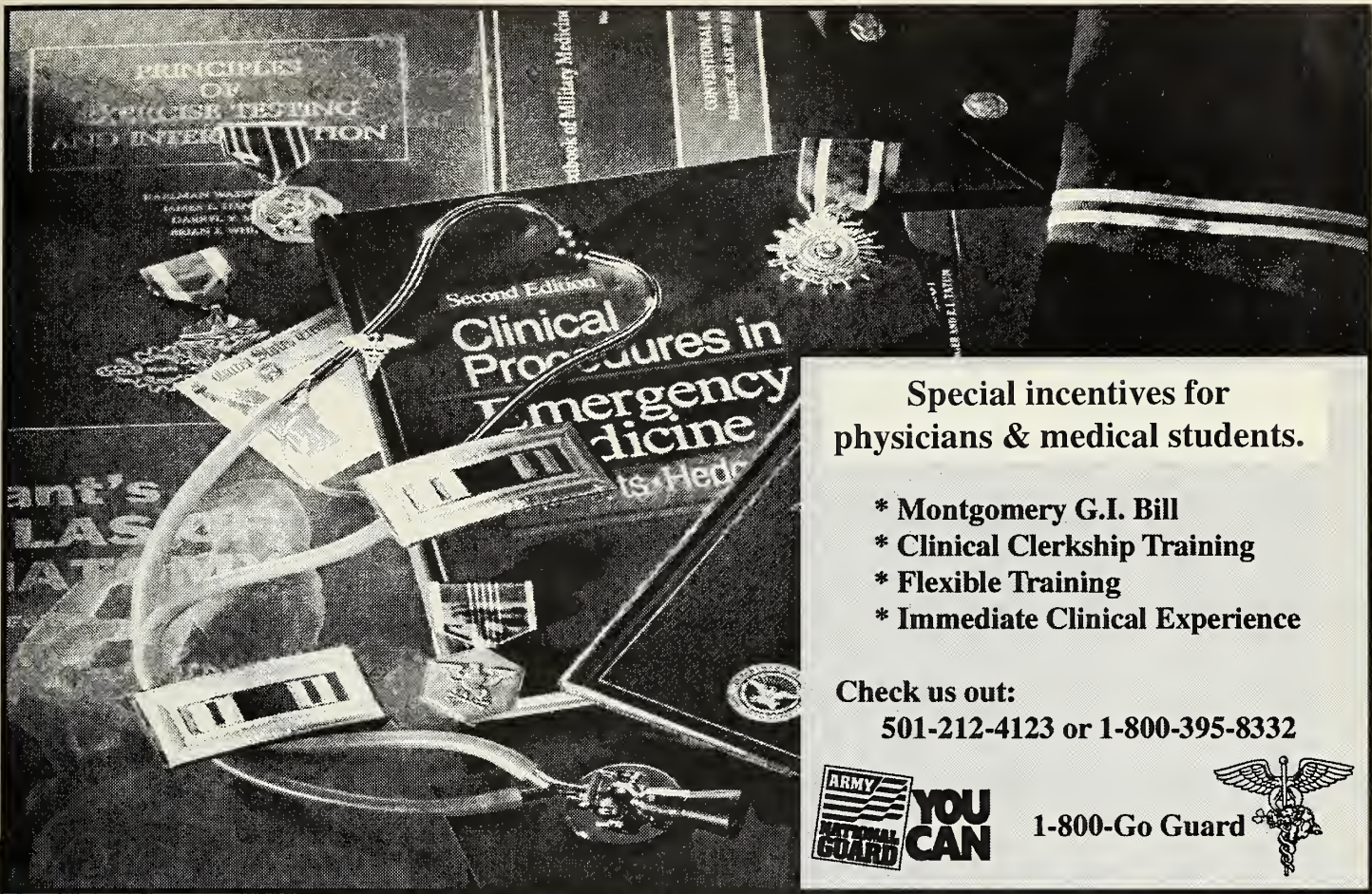
collected \$5,142 of the \$9,504 average per stay — about 54 percent of billed charges. Forty-six percent of charges were written off as discounts, bad debts or other causes. The U.S. average for uncollected charges is 46.75 percent.

Money for UAMS

The American Medical Association Foundation, the philanthropic arm of the AMA, gave more than \$17,000 to the University of Arkansas for Medical Sciences for medical education programs.

The funds were given in partnership with the Arkansas Medical Society as part of an annual program by the AMA Foundation that raises \$2 million nationwide to help offset the high costs of medical education and support for the areas of medical research.

"Throughout the AMA Foundation's history, it has worked to keep pace with the expanding and evolving needs of the medical community," said Dr. J. Edward Hill, president of the AMA Foundation, in a released statement. "By providing financial resources to medical schools, we believe we are helping guarantee that quality patient care and solid medical education maintain high levels of excellence."



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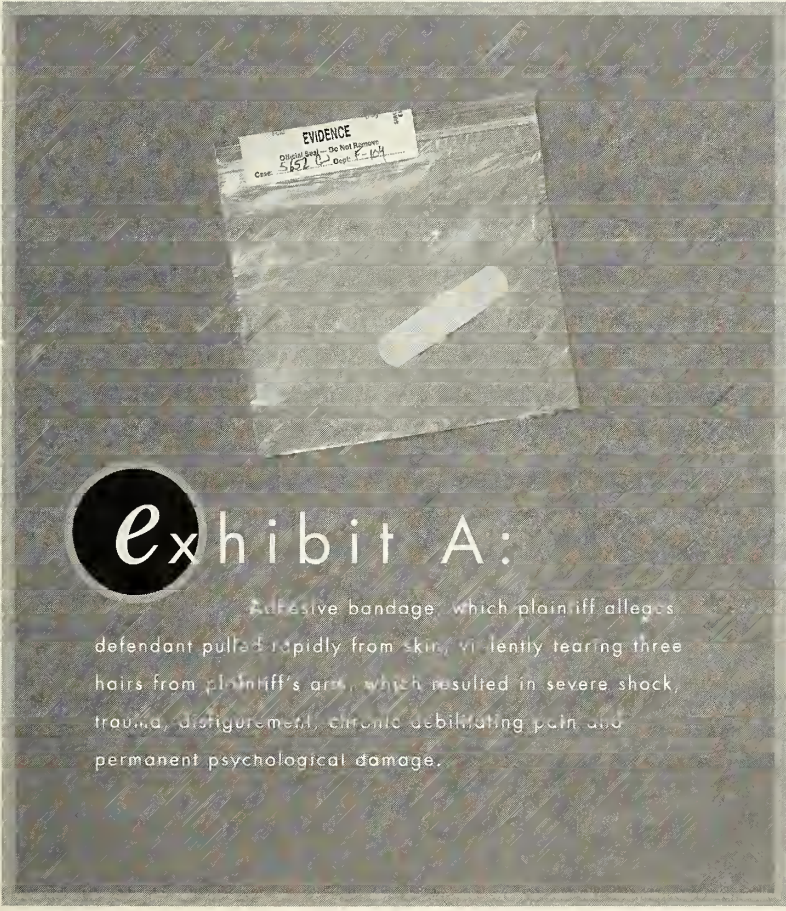


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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New President's Goals Include Tapping Younger Members

Lloyd G. Langston, MD, is not new to the leadership of the Arkansas Medical Society.

After Dr. Bud Irwin decided it was time for some "young blood" to come on board, Dr. Langston became an AMS councilor in the early '80s. Since then, he has moved his way up, serving as treasurer for six years and as president-elect in 1998.

Just as he was brought in as "young blood," Dr. Langston has the same vision for the next year.

"In the past, doctors have gotten involved with the Society after 10 to 12 years of being in practice," said Dr. Langston, an otolaryngologist in Pine Bluff. "But things are much worse now. The state, Aetna, Blue Cross Blue Shield are all dictating how you take care of your patient. And if we can't get the young physicians to see this, then by the time they realize it, it will be too late."

During this year, Dr. Langston, AMS officers and staff will spend time with medical students and residents helping them understand the need for organized medicine in the days of managed care.

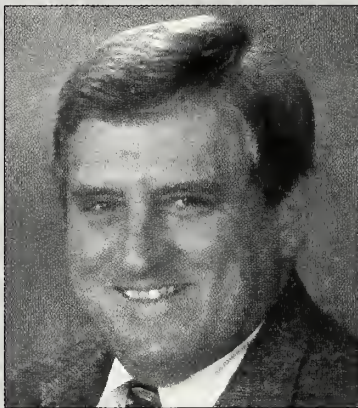
Managed Care Wave

The influx of insurance companies and managed care has posed many problems for physicians that Dr. Langston and AMS officers are working to remedy.

"The biggest challenge for doctors is maintaining the freedom to continue taking care of our patients without outside interference," he said. "Right now, we have someone who has no training telling us how to practice medicine."

One of Dr. Langston's four goals is to ensure the life of the physician-pa-

{ PRESIDENT'S PROFILE }



Lloyd G. Langston, MD
Private practice, South Arkansas Ear, Nose & Throat Clinic, Pine Bluff

Date of Birth:
Aug. 13, 1941

Marital Status:
Wife: Glenda
Three children: Allison, 25, Blake, 24, and Grant, 21

Hobbies and interests:
Hunting, fishing, golf, tennis

Education:
Mississippi State University, 1959-1963
University of Arkansas for Medical Sciences, 1963-1967, MD degree, BS in medicine
Internship at Confederate Memorial Medical Center, 1967-1968
Residency at Louisiana State University at Shreveport, 1968-1972

Military Duties:
Staff Otolaryngologist, 1972-1974, U.S. Naval Regional Medical Center, Oakland, Calif.

Certifications and Licensures:
Certified by American Board of Otolaryngology, 1974
Fellow, American College of Surgeons
Arkansas State Medical Board

Professional Organizations:
Arkansas Society of Otolaryngology
American Academy of Otolaryngology, Head and Neck Surgery
Jefferson County Medical Society
Arkansas Medical Society, treasurer, 1992-1999
AMS, president-elect, 1998
AMS, president, 1999

tient relationship. With the trend moving more towards managed care, there is a tendency to lose this, he said.

"The more attention given to patients, the better chance to preserve the best health care system in the world," he said. "Managed care is trying to destroy that. They don't even want to use the words physician-pa-

tient. Instead they use words such as covered lives and providers."

Another goal of Dr. Langston's is to create a special section of AMS dedicated to monitoring federal regulations on physicians, such as record keeping and confidentiality laws.

"We need a full-time person that just keeps up with these oppressive



Dr. Lloyd Langston, Glenda Langston, Barbara Moody and Dr. Michael Moody, at the Annual Session in Hot Springs.

programs by the federal government that are beyond comprehension," Dr. Langston said. "Right now, this is strictly talk from Washington, but we want to stay on top of it and help doctors defend themselves if need be."

As past chairman of the AMS' Long-range Planning Committee, Dr. Langston also plans to reactivate this committee. This will help the AMS focus on its goals for the 21st century, he said.

Society Involvement

Dr. Langston says the experience he has gained through serving as an AMS officer over the past years has prepared him to see these goals through.

As a councilor and treasurer, he helped move the AMS office to Little Rock and oversaw the hiring of a complete staff. Dr. Langston also participated in the creation of the Arkansas Health Care Access Foundation, a foundation made up of providers in Arkansas who provide free medical care to low-income Arkansans without medical insurance and not served by Medicaid.

He helped create the AMS' legislative affairs department, bringing staff member Lynn

Zeno on board to monitor laws and regulations affecting physicians.

On the managed care side, Dr. Langston helped AMS start a managed care company that was physician-controlled. The company was eventually sold, and now has regional boards across the state that oversee provider groups.

One of the biggest issues Dr. Langston has worked on for the AMS is the Society's relationship with the Arkansas Department of Human Services, which oversees Medicaid. A lawsuit occurred after the state threatened to dramatically cut physicians fees, but with the leadership of Dr. Langston and the other members of the executive committee, the AMS and DHS worked together to develop solutions that benefited both.

"All this has been great for the state of Arkansas," Dr. Langston said. "They come to us, we discuss the plan and where the problems will occur from a provider standpoint. It gets everyone involved and creates a lot less hassle.

"It saves a lot of money for the state of Arkansas. Through the work of the Society, we're willing to give up things for the betterment of the program." ■

"The biggest challenge for doctors is maintaining the freedom to continue taking care of our patients without outside interference."

— Dr. Lloyd G. Langston

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- Medicare/Medicaid issues
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- New treatments and technology
- Access to care for the indigent

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Arkansas Medical Society Publications

The AMS Membership Directory

A quick and easy guide to AMS physician members, the directory provides addresses, phone and fax numbers, specialties and E-mail addresses. Plus other health related information. The directories are printed each year in late July.

The directories are \$50 each. With a purchase of 2 to 10, \$45 each; 11 or more, \$35 each. (Note: All AMS members receive one free directory through the mail immediately after publication in August of each year.)

The AMS's Physician's Legal Guide

A compilation of state and federal laws affecting the practice of medicine in Arkansas, this guide is 170 pages on topics such as medical records, patient abandonment, medical board regulations, Antitrust Law, Workers' Compensation, & much more. The List Price is \$100.00. **AMS Member Price is \$70.00.**

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Inaugural Address

AMS Annual Session

Lloyd G. Langston, MD

Dr. Moody, honored guests, friends and fellow Arkansas Medical Society members, greetings. Thank you Medical Society for honoring me with this position and placing your trust in me. I pledge my best in upholding the office. I will give my best effort to live up to the standard set by all my predecessors.

I want to recognize some people who are very important to me, and without whose support this evening would not be possible. First, my wife, Glenda, who has tolerated Sunday meetings for years and has dealt with children and family problems too numerous to mention, so that I could participate with the Society. My clinic employees — these ladies keep me straight and organized. My nurse, Betty, makes calls, keeps my calendar and serves in the combined roles of friend, surrogate parent, conscience and right arm. Nancy Murdock and Tammy Studdard keep the wheels on the clinic. To Dr. Wayne Buckley and Dr. Stephen Shorts, my partners for so long, who have been willing to cover for me over the years, and to their wives, Janie and Julie, and all the other ladies in the clinic, I say thank you.

There are two physicians whom I greatly admire and to whom I owe a great deal that I would like to recognize at this time. Dr. Tom Ed Townsend, a past president of the Arkansas Medical Society, who not only chased me around as a tow-headed kid in order to give me shots but also serves as mentor and role model throughout my years of practice. Also, I want to acknowledge Dr. Bud Irwin. Dr. Irwin relinquished his council seat to provide my opportunity to be involved with the Arkansas Medical Society. He indicated he felt it was very important to get "new blood" into the organization. By allowing me to become involved, Dr. Irwin, without a doubt, forfeited his opportunity to serve as president of the Arkansas Medical Society. I truly owe him a debt of gratitude.

After being contacted by the nominating committee about this position, I

struggled with three problems. I hate being photographed, even for *The Journal*. I don't like being seated at the head table, and I really dreaded making a speech. I survived the photograph, and I am obviously handling and beginning to enjoy being at the head table. I determined that I would survive the speech if I kept it brief. To insure that decision, I made some promises to my office staff and the Medical Society staff that they would not be required to listen for long.

Let us look back while moving forward into the 21st century. Join me as I reminisce about my involvement with the society, while expressing some of my visions for future success. I have been reflecting about the changes and development in our society since I became a councilor. It is important for us to remember our successes in these days of sweeping change and frustration. Many exciting things have happened over the years, and I feel fortunate to have been involved. These events were the result of much hard work by many who worked for and with the Society.

I experienced the move of the AMS office to Little Rock. Ken LaMastus became CEO, and David Wroten came on board. I observed the construction of the building, which houses our office, and belongs to the Society. I participated in the development of the Arkansas Health Care Access Foundation, which was the result of collaboration between the Society and the state of Arkansas. This Foundation is one of the first volunteer projects in the nation by physicians, hospitals, pharmacists and other allied health professionals to provide temporary care, free of charge, to patients who are financially compromised but not eligible for Medicaid. This Foundation is still viable, and, I'm told, has served more than 50,000 patients.

Like many of us, I endured the Department of Human Services lawsuit. Ultimately this action greatly benefited physicians and patients participating in the Medicaid program, and even the Depart-



"Like many of us, I endured the Department of Human Services lawsuit. Ultimately this action greatly benefited physicians and patients participating in the Medicaid program, and even the Department of Human Services. The result of the suit is an outstanding working relationship between the Society and the Department of Human Services, which is the envy of all other states."

— Dr. Lloyd G. Langston

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ment of Human Services. The result of the suit is an outstanding working relationship between the Society and the Department of Human Services, which is the envy of all other states. I assisted in crafting the Legislative Affairs Department, necessitating the hiring of Lynn Zeno, as the head. I continue to be amazed at the influence that the Society exerts on the state Legislature and resulting successes and changes as a result of this effort.

And, lastly, I cooperated in our venture into managed care, which established one of the largest physician networks in the state. This effort established local units, which are physician-controlled. The endeavor provided physicians a voice during the incursion of managed care into our practices.

These accomplishments have provided for us a Society that is a highly respected organization with a strong legislative voice. The Society is a strong advocate for patients. It is also a formidable advocate for physicians, which has resulted in improvement in our individual practices.

In spite of these achievements, all is not well! How vividly I remember sitting with classmates and friends in 1967. I was a senior medical student when my roommate startled us all with a prediction of socialized medicine by 1977. HAH! Just as I thought! WRONG! We don't have socialization, but one would be hard pressed to conjure up a worse alternative than the managed cost and federal oppression we have experienced in 1999.

First, we had E and M. Then we saw the fraud and abuse initiative with the criminalization of the American physician and private medical practice by our government. Now on the horizon, according to Dr. William Plested of the Board of Trustees of the AMA, HCFA regulation of confidentiality of medical records, not in the insurance industry or managed care organization where the problem exists, but in the physician's office.

He indicated that plans by HCFA include assignment of "security levels" to each employee in your office (up to 40 different security levels) and requirement that records be kept in locked storage at all times. He said that when they are removed, the person removing them must sign them out on a ledger, with their signature, security level, date and time. This person must keep the chart under their di-

rect control (in their possession) until they log it in and lock it up. Then the next person can obtain the chart by following the same procedure. Can you imagine the confusion and delay when we see a patient and each person that must handle the chart must go through this procedure?

Oh, by the way, there will be a new division of enforcement to ensure that these requirements are met, and fines of up to \$10,000 per violation to be sure that these agents are paid. It is regrettable that the same government that intends to implement this plan in physician offices did not have such a security plan at our nuclear weapons research facilities. Perhaps if they had used this plan on their own agencies, we all would not be worrying about the threat of Chinese ICBMs armed with warheads that they built with plans taken from our research facilities. I did not dream in 1967 that the treatment of my patients would have oversight and dictation by CPAs, MBAs and government bureaucrats who know far less about patient care than I do about accounting. These business gurus have a different jargon for referring to the physician and patient. They use terms like covered lives, providers, payers and clients. They brag about buying physicians, market shares and bottom line profits, with little or no regard for the patient as a human being. Are they primarily interested in profit margin?

I did not dream in 1967 that my prescriptions would be evaluated by insurance-employed pharmacists who evaluate my decisions based on the use of "best drugs." Their description of "best" usually means the drug is the least costly for them and is likely owned by the insurance company or managed care company for whom the pharmacist works. Do these oversight personnel not regard outcomes, previous treatment of the patient or the patient's individual situation?

I did not dream in 1967 that our government would make public policy,

broadly accusing health care providers and physicians of fraud and offer rewards to patients who report them. Never mind that these patients may be malcontent or just confused about the billing procedure. I did not dream in 1967 that the assumption of guilt and fraud, with accompanying high monetary penalties, could be placed on a physician for a single charting deficiency. The patient may have experienced no harm, and the quality of care and outcome may have been faultless. Does being a physician mean that one cannot make a simple charting mistake without paying dearly?

I did not dream in 1967 that gun-carrying federal agents would invade our offices for the dangerous, high-risk job of reviewing charts. These agents are basically "bean counters." They count the number of items on a history and physical, system review and other recorded information. If the numbers don't add up, then we are accused of — you guessed it — fraud. These agents apply statistics from studies of small numbers of our charts to years of work and records. They demand exorbitant refunds to the government and levy outrageous fines with no reasonable right of appeal. The word oppression comes to mind. This data would never be considered statistically reliable in a business or scientific study.

Doesn't quality of care, treatment outcomes and work devoted to the patient count for anything?

I did not dream that one day there would be serious talk of physician unions and collective bargaining. When we are held responsible for health care costs that are dictated by insurance companies, state and federal regulations, and federal laws such as COBRA, what is a profession to do?

These situations remind me of a story about a man who saw his prize bird dog collapse. The gentleman grabbed the dog and rushed to the veterinarian. As he ran into the vet's office, he hollered, "Doctor,

**"I did not dream in 1967
that my prescriptions
would be evaluated by
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my decisions based on the
use of 'best drugs.' "**

— Dr. Lloyd G. Langston



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my dog has collapsed and he is sick, please help him!"

The vet took his stethoscope and light, listened to the dog's chest, looked at the dog's eyes and turned to the man and said, "Mr., I am sorry, your dog is dead."

The dog's owner would not accept the diagnosis. "I need another opinion," he said. The vet thought a minute, walked outside, came back in with a large, gray tomcat. He put the cat on the table with the dog. The cat bowed his back, hissed at the dog, reached out with his paw and scratched the dog's nose. The dog didn't move a muscle. The cat meowed, jumped off the table and walked out of the room. With that, the vet looked at the gentleman and said, "Sir, the cat says your dog is dead!" The dog owner, still not satisfied, replied, "Doctor, I can't accept the word of a cat that my dog is dead. I want another opinion!"

With that, the vet walked out, came back in with a large, black Labrador on a leash. The Labrador raised up on the table, looked at the other dog, barked and licked him. Still the dog didn't move. The Labrador turned to the vet, looked at him, barked and walked out of the room. With that, the vet said, "Mr., the Lab says your dog is dead!" By this time, the dog owner realized he was truly in trouble. So, he told the vet he would accept this diagnosis and wanted to know how much he owed so he could pay the bill and leave. The vet replied, "The bill is \$3,000." The man went ballistic. "Three thousand dollars," he screamed, "what do you mean? You have only been in here 10 minutes!"

To which the vet replied, "Yes, that's right. My fee is only \$50, but remember, you had a CAT Scan and the Lab." Sound familiar?

How do we tackle these challenges as we look toward the next century in medicine? As individuals, there is little anyone of us can do. But as the Arkansas Medical Society, there are options and actions which we may attempt. There are four suggestions which I will strive to initiate and complete in the next 12 months.

First: Many of our successes have been achieved by "planning our work and working our plan." As President, I commit to reactivating the Long-Range Planning Committee and developing a comprehensive, strategic plan to propel us into the

21st century. My goal is to present the plan to the Council or House of Delegates no later than next year's spring meeting. Input will be obtained from the membership through a variety of techniques — for example — questionnaires and interviews. The development of leadership for the future will be a priority of this committee.

Second: I am convinced that a plan for sustainable growth and membership retention is of the utmost importance. Focusing on the development of student and resident groups is essential. To remain viable, we must recruit young physicians and convince them of the necessity of organized physician activities. They must see the benefits that their patients and we would derive from Society membership and participation.

Third: I am determined to explore the possibility of developing a special section under Ken LaMastus and David Wroten, consisting of reimbursement specialists, to confront the threat of federal intervention and its incursion into our practices. Several states have already taken this action. Idaho is one of these. Idaho's experience has been significant because they were selected for a pilot study by HCFA, regarding fraud and abuse. At a recent AMA Leadership Conference, I visited with some of the Idaho physicians. They reported cases where penalties totaling \$70,000 or greater were incurred. After intervention by "reimbursement specialists," the penalties were reduced to several hundred dollars.

These "reimbursement specialists" assist members when the Feds come calling. These specialists have been very successful in reducing the level of financial loss to the physician. Their assistance also provides tremendous stress relief for the physicians. These individuals may be able to conduct individual surveys for members in order to prepare for evaluations. They may advise in the development of compliance plans for individual offices, in addition to leading seminars and educating members about

"We must never tolerate those who use jargon consisting of words like providers, clients, covered lives and market shares to destroy this relationship with our patients."

— Dr. Lloyd G. Langston

federal intervention. The area of federal intervention is changing so rapidly that it is impossible to keep knowledge current without using persons whose time is dedicated to that area alone. The costs of these specialists should easily be covered by fees charged for providing the services as described previously.

In concluding, I want to stress above all that we must strive to maintain the physician-patient relationship, which is our greatest asset. This is an asset that we must nurture and protect. The patient is not our enemy. Our enemies are those who would take away our freedom to practice our profession, causing our patients to be deprived of excellent

care.

We must never tolerate those who use jargon consisting of words like providers, clients, covered lives and market shares to destroy this relationship with our patients. I am confident that CEOs of these managed care companies and insurance companies, who are only concerned with the profit and cost containment, are not found on the positive side of delivering the world's best health care. But, rather, it is the relationship which American physicians have had with their patients, based upon our dedication to the patient's welfare, that makes our health system the envy of the world.

As I look back to those days as a student, remembering the arguments, discussions and predictions about the future of medicine, I wonder. Do some of these same discussions occur now at 4300 W. Markham or at your offices? I often ponder that old question: If we had known then what we know now, would you or I have chosen different professions? I think not. Physicians seem to have that unique dedication to the caring of those in our charge that no other profession quite equals. I predict that this ideal will move us forward into another millennium of service above self in caring for our patients. I hope we never lose that ideal. ■

Dr. Moody Key in Compromise with Arkansas State Medical Board



Dr. Michael Moody welcomes Dr. Lloyd G. Langston as AMS' new president.

Compromise is what describes the bulk of Dr. Michael Moody's year as president of the Arkansas Medical Society.

As outgoing AMS president, Dr. Moody, a Salem physician and medical director for the Arkansas Foundation for Medical Care Inc., said one of the biggest issues he worked on this past year was reaching a compromise with the Arkansas State Medical Board over regulations on long-term pain medications.

"The regulation wasn't patient- or physician-friendly," Dr. Moody said. "So we worked with the state medical board and formed an ad hoc committee to reach an agreement. Now, the regulation allows the board to fulfill their duty, which is reducing the over-prescribing of medications, while allowing doctors to prescribe adequate medications."

Working closely with Dr. Ray Jouett, chairman of the Arkansas State Medical Board,

**" We need to
be involved
and be
advocates
for our
profession
and our
patients."**

**— Dr. Michael
Moody**

helped restore the relationship between the AMS and the board. "And I think that's one of the biggest accomplishments of the year," Dr. Moody said.

Monitoring this year's legislative session took much of Dr. Moody's time. Working closely with AMS staff, Dr. Moody developed the society's agenda, which was at times difficult since physicians were on both sides of the issues.

"We had multiple issues this year with physicians on both sides," Dr. Moody said. "And that took lots of negotiations. We had to get physicians on both sides of the issue to see the necessity of a compromise, and doctors sometimes don't like to compromise."

Some of the bigger legislative issues Dr. Moody worked on included a proposal to have a licensing law for all X-ray technologists, which was supported by radiologists.

"We have 5,000 machines but

only 2,000 technologists," he said. "We had to have nonlicensed technologists to operate all these machines, especially those in chiropractors' offices and rural areas."

The AMS, the technologists and the radiologists worked out a compromise that called for a limited-license technologist, who could only do limited X-ray procedures.

Another compromise that came about under Dr. Moody's leadership was the bill that passed requiring that all health maintenance organizations in Arkansas have an out-of-network option. AMS staff and members tried to get a bill passed that would require all managed care organizations to allow any physicians that met the requirements

"We had multiple issues this year with physicians on both sides, and that took lots of negotiations."

— Dr. Michael Moody

into their networks.

"We were unable to get that passed, but again, worked out a compromise," Dr. Moody said.

From his experience with the Legislature this year, Dr. Moody said he would like to continue to get more physicians involved with public policy.

"We tried to get that done this year, and I hope the medical society will continue to work in that direction," he said. "Legislators and regulatory bodies, such as the Department of Insurance and the state medical board, all are passing regulations every day that affect our

practice and our patients. We need to be involved and be advocates for our profession and our patients." ■



*Clockwise (L-R):
Jim Strawn, Stephen Chaffin, Bill Smith*

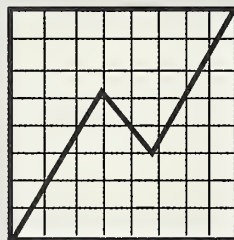
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Final Presidential Address

AMS Annual Session

Michael Moody, MD

Lynn Zeno says that he always writes his speeches the morning of. Well, from his great presentation, you all know that his was not written this morning. But at 5:30 this morning when I woke up trying to think about what I was going to say, this speech was not written. So, my thoughts today are with a lot of mixed emotions about a farewell address when I really do not feel this is a farewell.

This morning I looked at my speech from last year — the inaugural address which I started by saying that the success of my year would be best determined by the working relationship with the staff of the Arkansas Medical Society. If that is true, it has truly been a wonderful year because working with these guys, Mike, David, Lynn and Ken, and all the others has been very positive. The support of all the membership and the committees that we worked with has just been wonderful. These things have all combined to make this year very pleasurable and productive.

As I was looking back through last year's speech entitled "The Challenge of Change," one quote was "an organization will decline only if we fail to recognize the need for and embrace the necessity of great change." I again challenge you to consider the rapid evolution of medicine that we have all been talking about through this meeting.

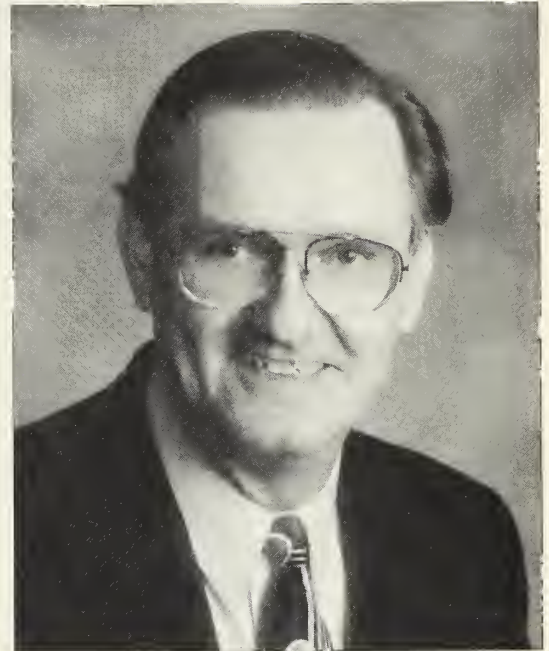
Medical practice is changing rapidly, but this great change in our profession should be an opportunity for improvement. We all should work constantly in that direction. I again remind you that our first and most important job is to protect the sanctity of the patient-physician relationship. Our patients really do remain our allies, and we really must continue

to be their advocates.

As I reminisce about the challenges of the past year, one of the first thoughts was of the friction between the Medical Society and the State Medical Board when we were standing here last year. In my opinion that no longer exists. With Dr. Jouett's leadership, our positive and mutually cooperative working relationship has been fully and totally restored. I think that's one of our great accomplishments for the last year.

One of the most enjoyable events of this past year was the UAMS White Coat Ceremony. This is a ceremony whereby all the freshmen medical students are indoctrinated into their first class and receive their first white coat upon entering medical school. I gave a brief address at that ceremony concerning the ethics of medicine. Looking out over all of those bright, young, enthusiastic, idealistic freshmen of the University of Arkansas Medical School was absolutely one of the most inspiring events of this past year. One thing that I gave them, with the support of the staff, was the American Medical Association Principles of Medical Ethics.

Every incoming medical student received a copy of these medical ethics. I'm not sure how often they've looked at it, but I still carry my copy and still remember one thing brought to their attention: "we must respect the law, but we also must recognize a responsibility to seek changes in those requirements that are contrary to the best interest of our patients." In other words, we have to affect public policy.



Michael Moody, MD

We have to follow policy. But when it is contrary to the interests of our patients, our code of medical ethics says that we have to advocate for change. I certainly want to continue working with Zeno and others in that direction.

As to the legislative session, under Zeno's leadership, in most cases we were able to put aside our own self-interest; and we did have doctors on one side and doctors on the other side of many issues. We put aside those self-interests to work toward the most beneficial policies not only for our profession but also for our patients. That is certainly what we need to continue advocating as an organization.

Thank you again for the expression of support that you've given by electing me to the AMA delegation. There is another quote that says, "Success is a journey, not a destination." With the continued support of my friends, colleagues and the AMS staff, I intend to continue that journey on behalf of the Arkansas Medical Society. Thank you and God bless. ■

Pine Bluff's Health Is Mission of Shuffield Award Winner

Julie Bridgforth has taken her community's health on as her personal mission.

This year's Shuffield Award winner is helping Pine Bluff citizens recognize the benefits of health and wellness. Whether it is leading a smoking cessation class or training a group of women to run the Susan G. Komen Race for the Cure, Bridgforth is constantly striving to better the health of her community.

As director of health promotions for the Jefferson Regional Medical Center Wellness Center, Bridgforth helps 1,600 members and countless others in the area live a healthier lifestyle.

"The Wellness Center has made Pine Bluff such a healthier community," Bridgforth said. "Pine Bluff is so active; now you see people running everywhere."

The center offers 25 aerobics classes, yoga, kick boxing, an array of cardiovascular equipment, an outdoor track, whirlpools, basketball and many lifestyle classes, such as stress management and weight control. Bridgforth oversees all these classes, giving active residents "a place to hang out."

"This isn't a job," she said. "It's a mission. I'm very passionate about what I do here. I used to run by myself, but now I run with 20 to 50 other people. Things have really changed around here."

But Bridgforth hasn't always been the active type.

"I spent my high school career trying to get out of P.E.," she said. "I started running when I turned 30 to lose weight, and started going to the next level, running in marathons and racing. Now my joy in running is watching other people run."

Bridgforth has participated in 19 marathons, including the Boston Marathon. She was inducted into the Arkansas Roadrunners Hall of Fame in 1997 and carried the Olympic Torch in 1996.

Another passion of Bridgforth's is central Arkansas' Susan G. Komen Race for the Cure, which she chaired in 1998. Bridgforth led the 5K run/walk, which boasted more than 17,000 women participants who raised awareness and funds for breast cancer research. For the past four years, she has served on the



Bridgforth

Susan G. Komen Breast Cancer Foundation board of directors.

Other community activities include serving on the American Heart Association board, the Arts and Science Center of Southeast Arkansas board and the Pine Bluff Clean and Beautiful Commission. In addition, Bridgforth conducts breast self-exam classes for

"It really
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see people turn
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They have less
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just feel like
completely
different people."
— Julie Bridgforth

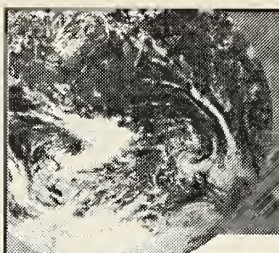
women throughout South Arkansas, writes a biweekly column on running and exercise for the *Pine Bluff Commercial* and speaks to community groups about health care issues.

"It really invigorates me to see people turn their life around," Bridgforth said. "They have less stress, work better and they just feel like completely different people."

Bridgforth's newest goal is to help businesses have healthier employees. Since so many people get their information from work, businesses have a great opportunity to inform employees about their health, she said.

"I want businesses to realize the benefits of having healthy employees, things such as less absenteeism, more productivity," she said. "It really does affect a business' bottom line."

Bridgforth, a University of Arkansas at Fayetteville graduate, lives in Pine Bluff with her husband, Bill. ■



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1999 Arkansas Medical

The 123rd Annual Session was held April 29-May 1 in Hot Springs. Members and guests attended excellent educational programs, visited exhibits, made new friends and renewed old friendships at the social activities.

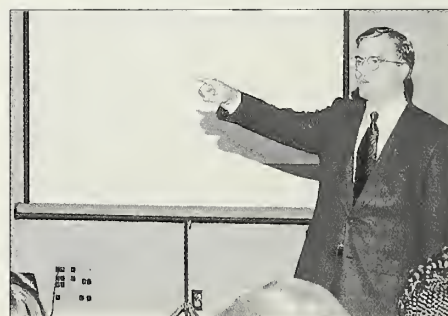
Dr. Michael Moody, past president, and Dr. Lloyd Langston, new president.



Lloyd Langston, MD, takes oath of office for president with AMS past presidents looking on.



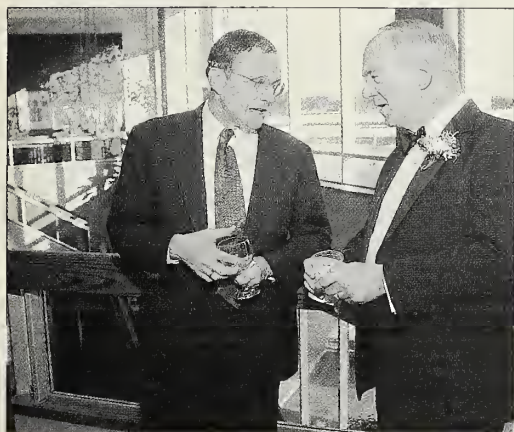
Steve Thomason, MD, introduces speakers for "Compliance Planning for Physicians."



John Armstrong, MD, Young Physician Seminar speaker.

Society Annual Session

Gerald Stolz, president-elect, escorted to podium by past AMS presidents Dr. J. Larry Lawson and Dr. John Crenshaw.



Mike Mitchell and William N. Jones, MD.



Margaret Arthur, MD, speaks about patients who use alternative medicine.



Lyda Campbell presents I. Dodd Wilson, MD, with check.



Julie Bridgforth, Shuffield Award winner, with Drs. Crenshaw and Langston.



Joe Gagen, Shuffield Luncheon speaker.

1999 Arkansas Medical Society Annual Session

Arkansas Health Care Access Foundation was established by Arkansas Medical Society to help provide medical care to Arkansas' poor uninsured. Dr. Michael Young, vice president of Arkansas Health Care Access Board of Directors, presents the Outstanding Spirit of Service Award to Conway's Bart Throneberry, MD, who exemplifies the giving spirit of Arkansas physicians.



(at far left)
Councilor Dr.
Michael Young and
Gail Young,
Alliance president-
elect, at the
reception.

Medical students at
President's Reception.

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The Fifty Year Club



The Fifty Year Club honors those physicians who have held a license to practice medicine for 50 years and have loyally and effectively served the community and — by skill and devotion to high ideals — upheld and maintained the standards of the medical profession. The Arkansas Medical So-

ciety hosted a luncheon for members of the Fifty Year Club April 29, 1999, at the Park Hilton Hotel in Hot Springs.

Physicians who were inducted into the Fifty Year Club this year are: Robert L. Baker, MD, Mountain Home; John H. Barrow Jr., MD, Helena; Kenneth E. Beaton, MD, Wynne;

Frederick B. Berry, MD, Roland; Vance J. Cram, MD, Wynne; Billy D. King, MD, Jonesville, La.; L. V. Ozment, MD, Camden; Donald I. Purcell, MD, Paragould; Walter G. Selakovich, MD, Little Rock; Bernard C. Smith, MD, Bradford; Eugene J. Towbin, MD, Little Rock; and Charles F. Wilkins Jr., MD, Russellville. ■

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Report of the Council



Members of the Arkansas Medical Society Council during the 1999 Annual Meeting in Hot Springs.

Summary of Actions Taken

The Council met on Thursday, April 29, 1999, and the following business was received and transacted:

1. Minutes of the following meetings were approved: Feb. 2, 1999, Council meeting; Feb. 24, 1999, Executive Committee meeting; March 3, 1999, Executive Committee Conference Call; and March 31, 1999, Executive Committee meeting.

2. The AMA's Principles of Medical Ethics, which represent the fundamental ethical precepts of medical practice, were presented for information. The AMA had requested input from members.

3. Procedures for suspending or terminating an Arkansas Medical Society member were presented for approval. A motion was approved to refer this draft to the Bylaws Committee to evaluate the need for the document, correct wording and clarify the document and to report back to the Council at a future meeting.

4. The Council approved dues exemption requests from component societies.

5. The Council gave its approval for an ad hoc committee to be appointed to fill vacancies on the Medicare Carrier Advisory Committee when nominations are not received from the specialty societies.

6. The Council made the following appointments:

- **Budget Committee:** Anthony Johnson, Little Rock

- **Journal Editorial Board:** Jerry Kendall, Camden, representing family practice; reappointed Lee Abel, Little Rock

- **Medical Education Foundation for Arkansas:** Jan Turley, Rogers

- **Pension Plan:** Reappointed Wayne Elliott, El Dorado

- **Arkansas Medical Foundation:** Reappointed John Lynch, Jonesboro, and Karen Ballard, Little Rock

- **Medicare Carrier Advisory Committee:** Reappoint Kerry Pennington, Warren, representing family practice; reappoint Samuel Landrum, Fort Smith, representing general surgery; John Bayliss, Little Rock, representing nephrology; reappoint Robert Porter, Little Rock, representing orthopedic surgery; Curtis Patton, Forrest City, representing pediatrics; Gerald Stolz, Russellville, representing pathology

- **Medical Student Councilor:** Karen McNiece, Little Rock

- **Arkansas Health Care Access Foundation Medical Student Member:** Twyla Norsworthy, Benton

7. The Council approved Tom Eans of Little Rock to fill the vacancy in the Eighth District as Councilor.

8. The membership and budget reports were accepted for information. ■

Report of the House of Delegates

Summary of Actions Taken

The House of Delegates met on April 29 and May 1, 1999.

1. Adopted the minutes of the November 1998 House of Delegates meeting.
2. Election of officers:
 - **President-elect:** Gerald Stolz, MD, Russellville
 - **Vice President:** Steven Thomason, MD, Little Rock
 - **Treasurer:** Dwight Williams, MD, Paragould
 - **Secretary:** Carlton Chambers, MD, Little Rock
 - **Speaker of the House:** Anna Redman, MD, Pine Bluff
 - **Vice Speaker of the House:** Kevin Beavers, MD, Russellville
 - **Delegate to the AMA:** J. Larry Lawson, MD, Paragould (Dr. Lawson will finish the uncompleted term, 1/1/98-12/31/99, of Dr. Weber and from 1/1/2000-12/31/2001)
 - Michael Moody, MD, Salem (Dr. Moody will finish the uncompleted term (1/1/98-12/31/99) of Dr. Larry Lawson and from 1/1/2000-12/31/2001); Lloyd Langston, MD, Pine Bluff (Dr. Langston will finish the uncompleted term, 1/1/99-12/31/2000, of Dr. Anna Redman)

Councillors:

- | | |
|--------------------|--|
| District 1: | Joe Stallings, MD, Jonesboro
Joe Jones, MD, Blytheville |
| District 2: | Lloyd Bess, MD, Batesville |
| District 3: | Dennis Yelvington, MD, Stuttgart |
| District 4: | John Lytle, MD, Pine Bluff |
| District 5: | William Dedman, MD, Camden |
| District 6: | Michael Young, MD, Prescott |
| District 7: | Brenda Powell, MD, Hot Springs |

- | | |
|---------------------|--|
| District 8: | Joseph Beck, MD, Little Rock
C. Reid Henry, Jr., MD, Little Rock
William Jones, MD, Little Rock
J. Mayne Parker, MD, Little Rock
Anthony Johnson, MD, Little Rock
Samuel Welch, MD, Little Rock |
| District 9: | Anthony Hui, MD, Fayetteville
Jan Turley, MD, Rogers |
| District 10: | Robert E. Sanders, DO, Fort Smith
Mike Berumen, MD, Fort Smith
Medical student: Karen McNiece,
Little Rock |

3. Approved the report of the April 29, 1999, Council meeting.
4. Accepted reports presented on the Consent Calendar.
5. Approved the following nominees for positions on the State Boards:
 - **Sixth Congressional District, Arkansas State Medical Board:** David Jacks, MD, Pine Bluff; Kimberly Garner, MD, Pine Bluff; Paul Wallick, MD, Monticello
 - **Third Congressional District, Arkansas State Board of Health:** Linda McGhee, MD, Fayetteville; Gary Myers, MD, Russellville; Robert Sanders, DO, Fort Smith
 - **Fourth Congressional District, Arkansas State Board of Health:** John W. Smith, MD, Hot Springs; Eugene Shelby, MD, Hot Springs; Michael Young, MD, Prescott
 - **Member-at-Large Position, Arkansas State Board of Health:** Robert Miller, MD, Helena; David Murphy, MD, Russellville; Anthony Hui, MD, Fayetteville. ■

New Alliance President Targeting School Violence as Priority



Young

As president of the Arkansas Medical Society Alliance, Gail Young of Prescott hopes to get the Alliance even more involved in community issues, such as preventing school violence, drunk driving and domestic violence.

"We want to get the word out to more people and let them know that people who practice medicine really are here to help," said

Mrs. Young, a high school chemistry and physics teacher.

"My No. 1 goal is to work more on S.A.V.E., which stands for Stop America's Violence Everywhere," Mrs. Young said. "With all the school violence, I think we really need to work on that."

Other priorities Mrs. Young has for the Alliance include advancing the group to become more politically active and increasing membership.

"We want to get more people involved and also establish an e-mail system so we can e-mail our members current information," Mrs. Young said. She also hopes to increase activity between the Alliance and the student spouses' organization at the University of Arkansas for Medical Sciences.

Mrs. Young said strengthening the physician community is extremely important because, "any time the medical community has problems, the Alliance has problems."

Another goal of Mrs. Young's is to develop a web site so information will be readily accessible to Alliance members and community residents.

After the web site is up and running, members will be able to access the site through the Arkansas Medical Society's web site at www.arkmed.org.

Last year the Alliance worked on a project that sent S.A.V.E. coloring books to local elementary school children, "but we didn't order enough, and I would like to be able to put one in the hands of each child this year," Mrs. Young said.

The coloring books are given to children in kindergarten through the fourth grade and promote the theme "Hands Are Not for Hitting."

The AMS Alliance touts 13 counties with active groups that each work with battered women's shelters in the area. Mrs. Young said she would like to see involvement with these shelters grow.

Mrs. Young's husband, family physician Michael Young, has been in practice in Prescott for 25 years. Gail Young recently won the Arkansas Physics Teacher of the Year Award. ■

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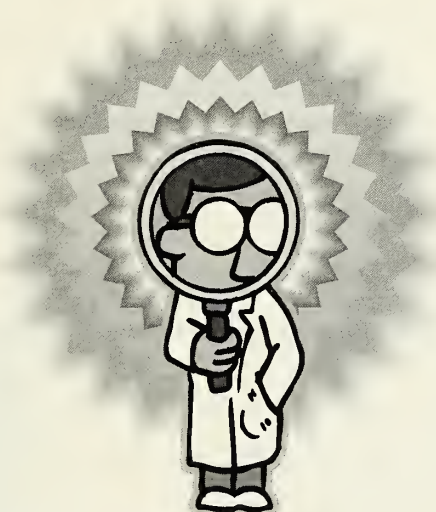
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Patient Choice Tops This Year's Legislative Session

This year's session of the Arkansas Legislature proved to be a busy one for the Arkansas Medical Society. Bills ranging from a Patient Protection Act to an act authorizing the Arkansas State Medical Board's credentialing information system were addressed.

Lynn Zeno, AMS director of governmental, worked closely with AMS officers and utilized the AMS grass roots network to lobby legislators and write policy affecting physicians. But one issue — prompt payment from insurers — was not adequately addressed. A bill was passed in the House of Representatives 90-2, but then failed in a Senate committee. This issue is AMS' priority for the interim and the 2001 legislative session. Goals for a prompt payment bill include developing a database that tracks delayed payments to providers, inundating the state Insurance Department with patient and physician complaints, scheduling joint meetings with the state insurance commissioner and hospital and physician representatives and scheduling joint meetings with individual legislators and hospital and physician representatives.

The following highlights some of the most important legislation to come out of the last session, which ended in April.



Act 1469

(Formerly Patient Protection Act — Any Willing Provider)

An act to assure freedom of choice among health benefit plans.

- Requires health maintenance organizations to offer a point-of-service option to each enrollee on an annual basis, allowing patients to receive covered benefits from out-of-network providers.

- The difference in benefit levels (co-payments, deductibles and dollar limits) between the in-network and out-of-network plans cannot exceed 25 percent.

- Employers must make an equal contribution regardless of which plan is selected.

- Reimbursement for out-of-network providers is based on usual and customary rather than the in-network fee schedule. However, co-payments and other cost-sharing features may be different.

- Pricing for the optional POS plan must reflect an 80 percent loss ratio.

Act 1410

An act to authorize the Arkansas State Medical Board to establish a credentialing information system.

- Makes permanent the State Medical Board's centralized collection system for information needed by hospitals, HMOs, managed care organizations and others who credential physicians.

- Participation by physicians and credentialing organizations is mandatory, thereby eliminating costly and duplicative verification processes.

- Program start-up costs will be funded by an initial \$100 increase in physician licensing fees for 2000-2001.

- After the data is collected, the program will be funded by user fees. Physicians may not be charged a credentialing fee by a credentialing organization.

Act 1200

An act to establish a program of quality assessment and improvement and to require all health carriers and networks to maintain grievance systems.

- All health carriers and networks will make arrangements for handling and resolving grievances. They must maintain records of

grievances filed concerning the quality of health-care services.

- Health carriers must submit a periodic report to the director of the state Department of Health describing the process and procedures for resolving grievances. The report should include total number of grievances handled, a compilation of the dates of the grievances, reasons for them and resolution of each grievance.

- Health carriers must maintain quality assessment and improvement programs and must maintain records measuring the outcomes of health-care services.

Act 1071

The Consumer-Patient Radia-

tion Health and Safety Act

An act to establish licensing requirements for all persons who perform X-rays.

- Creates a new category of "limited license technologists." The act grandfathers in all persons currently performing X-rays.

- Persons not grandfathered in must pass a license exam designated and approved by the Board of Health.

- New employees will be granted a temporary license immediately upon request.

- Limited license technologists may take X-rays of the chest and skeletal structures.

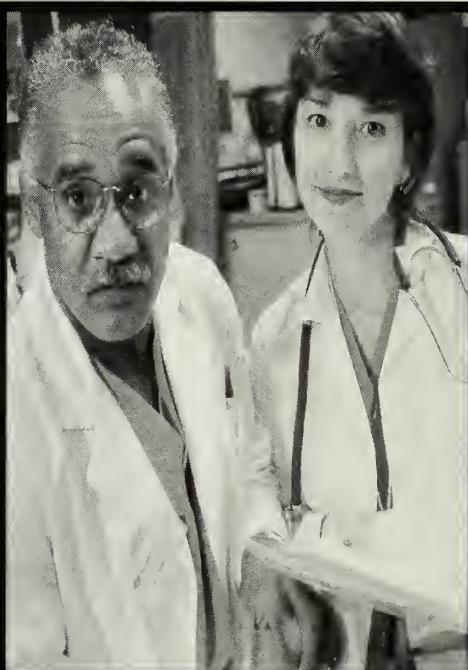
- Licensees must complete six hours of continuing education annually. ■

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OBITUARY

Dr. Steven Morris Moore, 43, of Jonesboro passed away Dec. 21, 1998, at M.D. Anderson Cancer Center in Houston.

He graduated in 1973 from Little Rock Central High School. He received his bachelor of arts, magna cum laude, in chemistry and mathematics from Vanderbilt University in Nashville, Tenn., in 1977. In 1981, he received his doctor of

medicine from the University of Arkansas for Medical Sciences in Little Rock. He completed his residency in radiology at the University of Tennessee in Memphis, Tenn., in 1985, before joining Associated Radiologists LTD in Jonesboro.

Survivors include his wife, Kathy; his parents, Jesse and Wanda Moore of Little Rock; two sisters and brother-in-laws, Kay and Larry Payton of Tulsa, Okla., and Leslie and Mark Elledge of Richardson, Texas; and four nieces and nephews.

IN MEMORIAM

The following members of the Arkansas Medical Society who passed away this past year were remembered during the 1999 AMS Annual Session:

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Vol. 96 No. 2

July 1999

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Special Report: Holt-Krock Clinic Given "Sparks" of Life



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Little Rock's
Health Care
Providers'
Response
to Flight
1420 Crash

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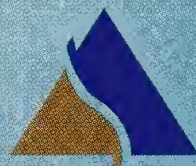
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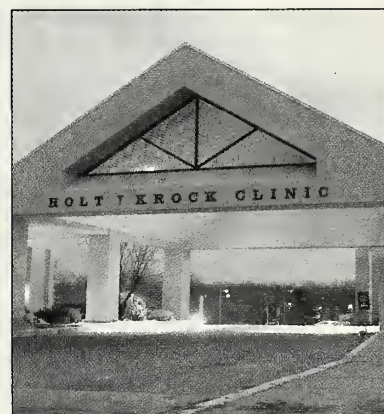
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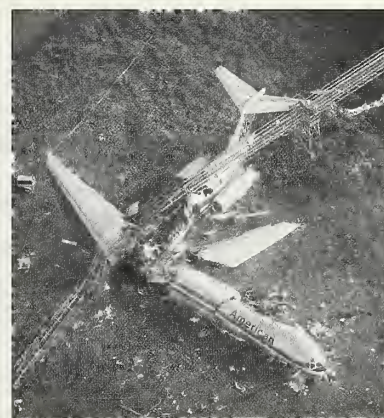
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On the cover: The leadership of Sparks Medical Foundation, which will own Holt-Krock Clinic by August, includes, from left, Dr. Robert Janes, chairman of the SMF Executive Council; Jeannie Parham, senior vice president of SMF; Dr. Stephen A. Edmondson, vice chairman of the SMF Executive Council; and Michael Helm, CEO of Sparks Regional Medical Center.



The sale of the 77-year-old Holt-Krock Clinic in Fort Smith will close by August.

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The crash of Flight 1420 took 11 lives.

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Selecting Malpractice Insurance Based on Low Rates is the Original High Risk Procedure.



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COMMENTARY**TMI and TLW**

LEE ABEL, MD

The caduceus is a well known symbol for the medical profession, but exactly what this winged staff is has never been very clear to me.

I don't think I was taught this in medical school, and probably most physicians aren't. The caduceus has always just seemed a mere decorative item, rather than something of any significant meaning. Then I read in a Robertson Davies novel the story of the caduceus and now it seems very meaningful. The story, as one of the characters in the novel tells it, goes thusly: "Once when Hermes walked abroad he came on two snakes fighting furiously. To make peace and establish balance or reconciliation or whatever, he thrust his staff between the snakes and they crawled up it, still hissing, but this time in concord, and they have remained twined about the staff of the healer to this day. And what are the snakes? You could call them Knowledge and Wisdom."¹

Something most physicians were taught in medical school is the truism that medicine is both an art and a science. Thus, it would be very familiar for us to see the snakes as symbolizing these two polarities, that is the humanistic/spiritual/nonquantitative side of medicine and the technical/scientific side. It is less familiar, but very intriguing, to see the snakes as symbolizing knowledge and wisdom. Have knowledge and wisdom ever "fought it out in the street" as the story of the caduceus goes? Aren't they basically the same thing? They do have similar meanings, but they aren't the same thing, and to this idea I'll return later.

**Have
knowledge
and wisdom
ever
"fought it
out in the
street" as
the story of
the
caduceus
goes?**

Maureen Dowd, the Pulitzer Prize-winning columnist for *The New York Times*, wrote last year about what she called TMI or too much information. She wrote this in reference to the media's fixation on the sexual lives of politicians. She felt that many of the details being reported were TMI. She went on to say that the prospect of hearing about the private sexual affairs of certain members of Congress, mentioned by name, was way, way TMI. Though she was being satirical, is it really possible in our society to have too much information? This after all is the "information age," and when it comes to information, the dominant theme in our society is the more the better.

I think I see examples of TMI in my practice. Recently, I saw a older woman who presented handouts on each of her five prescription medications. They had been given to her at a new pharmacy she had tried. She had been quite upset to read the very long list of possible side effects and began to experience some of them. (A reminder of the reality and power of the nocebo effect. Fortunately, she did not stop her medication). The number of side effects listed on the handouts was so large and many of them so rare (hydrochlorothiazide was listed as a cause of abdominal pain) that the information became worthless.

Perhaps we doctors don't always educate patients well enough about their medicines, but the solution is not to give all patients reams of information without individualizing the information and making sure it is relevant, appropriate and understood. The information given to this woman had been done with good intent, but it hurt more than it helped.

The information revolution has led to an astonishing amount of information available to the public. This has many benefits, and it has led to some problems. The print and broadcast media have a huge appetite for medical "news," and a high priority is placed on making the news entertaining. Thus the emphasis is on the seemingly miraculous (organ transplantation), the frightening (flesh-eating strep), and the contradictory (fiber may not protect against colon cancer).

Preliminary studies may receive wide attention, new findings may not be placed in the proper context, or the information may be largely irrelevant to a particular population (several of my patients have the impression from media reports that Arkansans should get the Lyme vaccine). Medical researchers may call press conferences and in their enthusiasm exaggerate the significance of their work. Even when the reporting is accurate, the challenge of fitting complicated medical issues into sound bites can lead to distortions. It's possible to end up with unrealistically optimistic expectations about what medicine can do, while at the very same time also develop cynicism about the ability of scientific research to settle any question.

Media reporting is only one source of medical information disseminated to the public. Pharmaceutical companies spend huge amounts on advertising medicines (prescription and non-prescription). These advertisements do succeed in increasing drug sales and do heighten people's awareness of symptoms and

illness.

Authors of best-selling books promote a myriad of controversial theories and therapies. Hospitals, insurance companies and doctors also spend large sums on advertising. Sometimes this information is educational and a public service, but as with all advertising, there may be aspects of it that are much more self-serving than public-serving. The newest source of medical information is the Internet. Unlike the above sources of information that are hard to avoid, it requires some initiative to get on the information highway. The Internet contains much valuable information, but much erroneous information is also available. How many people are able to tell the difference?

Much of the information being broadcast fills up time and space, but it's useless. It's just information clutter; an example of more being less. It may not always be harmless. It can distract us from what is important and distort our perspective. We worry about Ebola virus or brain tumors and yet continue to smoke (maybe we even smoke more). The hype over a new drug or a new medical procedure may persuade us that our health is somebody else's business.

The focus on rare diseases, unusual outcomes and improbable risks can increase feelings of insecurity. Instead of being enlightened, we just have more to worry about. When you forget your keys; it's not just forgetting your keys; it could be the first sign of Alzheimer's.

Of course, the information revolution has affected many aspects of society besides medicine. We know about storms on the other side of the world, we know minute details about celebrities and sporting events, we know where the Dow closed, we know innumerable advertising slogans, but how well do we know ourselves?

**Even when
the reporting
is accurate,
the challenge
of fitting
complicated
medical
issues into
sound bites
can lead to
distortions.**

Maybe TMI is hazardous to health and happiness.

Which brings us back to the question of the difference between knowledge and wisdom. Information, knowledge and wisdom are synonyms. According to Webster's Dictionary, information refers to "facts told, read, or communicated that may be unorganized and even unrelated."² Drowning in unrelated facts is not an education, and tuning out the information onslaught is not ignorance; it can be healthy. Knowledge is defined as "an organized body

of information, or the comprehension and understanding consequent on having acquired and organized a body of facts."³ Knowledge can be powerful. It can improve lives and improve society. Wisdom is more difficult to define but "is a knowledge of people, life, and conduct."⁴ It involves discernment, insight and experience. A character in Davies' novel points out that wisdom is not just experience; it's experience understood. To be wise is also to be kind and compassionate. One could have acquired great knowledge, but if kindness and compassion has been lost, then one doesn't have wisdom.

In a couple of years one of two competing groups will probably have succeeded in the race to sequence the entire DNA of the human genome. This will bring us a great amount of knowledge and much potential benefit, but it won't make us wiser. Wisdom can't always be gained in a straightforward way. Pulling an "all nighter" cramming for a test may increase your knowledge but may not increase wisdom.

We learn wisdom in many different ways. Sometimes it is fostered by slowing down, reflecting, praying or meditating, all of which may seem "nonproductive" in our busy, achievement-oriented society. Patients, friends,

Continued on page 44

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Changes to Journal Will Help Physicians Stay Abreast

Perhaps by now you've noticed that changes are being made to *The Journal of the Arkansas Medical Society*.

While many of the changes are cosmetic, you should also begin to notice changes in the type of information presented. Do you want to know how your colleagues in Fayetteville are responding to managed care? How about which insurance plans pay promptly? You probably won't find it anywhere else, so watch for future issues.

Hopefully, this column and the feature articles coming in future months will provide Arkansas physicians with a broader view of their medical society and a better understanding of the events shaping the practice of medicine in Arkansas.

In this column, we will attempt to keep you informed about what your medical society staff and leadership are doing on your behalf.

Over the past year, insurance company payment practices have reached the breaking point with physicians, patients and many state legislators. In April, a prompt payment bill supported by the AMS passed the Arkansas House of Representatives by a vote of 87-2 only to stall in the Senate Insurance and Commerce Committee during the final days of the session.



Arkansas' Insurance Commissioner Mike Pickens has responded by convening a task force of interested parties to recommend new regulations on prompt payment. AMS staff members serving on the task force will be working with other health associations during the summer to recommend changes that will require insurance companies and health maintenance organizations to pay claims in a more timely fashion. If this objective cannot be accomplished by regulation, the Arkansas Medical Society will begin a grass roots effort to pass legislation during the next legislative session.

AMS staff also will be working with the Arkansas Workers' Compensation Commission to develop a new medical fee schedule for work-related injuries. In 1994, the Arkansas Medical Society helped develop the first medical fee schedule for the Commission. Since that time, changes in CPT coding and inflation have rendered the schedule obsolete.

The Commission has asked the AMS to again assist its staff to develop a revised fee schedule. Meetings have been scheduled during June and July for this purpose. The goal will be to develop a schedule that is fair and reasonable with some type of feature that will enable the Commission to easily update it annually.

AMS President Lloyd Langston, MD (Pine Bluff) has announced that a long-range planning committee will be established to help identify trends affecting Arkansas physicians and develop appropriate initiatives to respond to them.

The Arkansas Medical Society has a proven track record of meeting the needs of Arkansas physicians. However, every successful organization must continually be alert to trends and changes affecting their membership. Take for example the trends in physician ownership. More and more, physicians are opting to become employees rather than owners. While this trend is not new, it is growing at a fast pace. The needs of physicians as "employees" sometimes vary greatly from those of physicians as "employers" or "owners." The AMS must be positioned to meet the changing needs of both of these groups or risk losing their participation.

For questions or comments on these topics call the AMS office at (501) 224-8967 or (800) 542-1058. You also can e-mail the AMS at ams@arkmed.org.

Continued from page 42

family, strangers and even people we might secretly consider our "enemies" can, knowingly and unknowingly, teach us wisdom. Human wisdom is not an all-the-time phenomenon. We all make mistakes and have our moments of foolishness. In our society we seem to almost worship information, but our most serious mistakes (most of mine at least) seem to occur not so much because of lack of knowledge but because of too little wisdom or TLW.

To be a good physician requires a lot of knowledge, and this must be balanced with a lot of wisdom. Because of the amazing advances of medical science it's easy to undervalue "the other snake." I get reminded of this when I see patients who aren't helped by anything that the scientific side of medicine currently has to offer.

A rarer, but more painful reminder is when patients get worse because of medical technology. All our information and technical knowledge, wonderful though it can be, doesn't make us wiser than the ancients. This carrying of the caduceus can seem like a job better suited for the gods than for us mere mortals. But one of the wonderful ironies of life is that our mistakes, if we allow them, can become our very best teachers of wisdom. I find that piece of information very hopeful. ■

References:

- 1) Robertson Davies, *The Cunning Man* (New York :Penguin Books, 1994), p 166-167.
- 2) Webster's New Universal Unabridged Dictionary (New York: Random House, 1996), p 980.
- 3) Webster's, p 980.
- 4) Webster's, p 980.

Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic. He is a member of the editorial board for The Journal of the Arkansas Medical Society.

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I N + T H E + N E W S

Blood Pressure Tops Doctors' List for CVD Prevention

It's a fact that cardiovascular disease is the leading cause of death in the United States, although doctors use a wide variety of services to prevent and treat this ailment.

According to a study by researchers at Massachusetts General Hospital — paid for in part by the agency for Health Care Policy and Research — blood pressure measurement topped the array of prevention services. Blood pressure was measured in 50 percent of the 31,000 adult visits to doctors. Counseling for exercise and treatment with antihypertensives were next at 12 percent, followed by weight counseling (6 percent), cholesterol testing (5 percent), cholesterol counseling (4 percent), smoking counseling (3 percent) and lipid-lowering medications (2 percent). Cardiovascular disease accounts for 41 percent of deaths in the U.S.

The study, which included 1,521 physicians, also found cardiologists were more likely to provide prevention services than were other doctors.

The research was conducted by Dr. Randall S. Stafford and David Blumenthal. It was published as "Specialty Differences in Cardiovascular Disease Prevention Practices" in the *Journal of the American College of Cardiology*, 32. ■



Clinton Plan Could Give Agency Power to Choose Contracts

The Clinton administration is looking into a plan that would give the Health Care Financing Administration power to choose Medicare fee-for-service benefits contracts. Medicare pays about \$1.25 billion for hospital services each year. The plan would leave some hospitals without Medicare contracts.

Other plans being considered include adding a prescription drug benefit to Medicare and using 15 percent of the federal budget surplus (about \$700 billion over 15 years) to solidify Medicare's hospital trust fund. The extra money would keep the fund solvent for at least an additional 12 years.

Health and Human Services Secretary Donna Shalala has said selective contracts and bidding would make Medicare more efficient and keep costs down. ■

Reporting New Hires Helps Find Parents Who Owe Child Support

A relatively new federal law designed to find parents who owe child support requires employers to report new hires to the Arkansas New Hire Report-

ing Center within 20 days.

The law is part of the 1996 Welfare Reform Act; the Arkansas New Hire Reporting Law went into effect Oct. 1, 1997. The law is intended to speed the process of finding noncustodial parents who aren't keeping up with child support payments. The system is expected to decrease the number of families who depend on welfare, Medicaid and food stamps.

Call (501) 376-2125 or (800) 259-2095, or visit the web site at www.AR-Newhire.com for more information. ■

UAMS Awarded for Family Practice Program Efforts

The University of Arkansas for Medical Sciences received the Gold Achievement Award from the American Academy of Family Physicians for having a high percentage of graduates who have entered family practice residency training programs since 1996.

Thirty-three percent of UAMS graduates since 1996 have entered family practice programs. That's second in the nation, according to I. Dodd Wilson, dean of the College of Medicine.

"Having the department of family and community medicine present on the main UAMS campus helps expose medical students to family medicine throughout their four years of medical school,"

said Dr. Geoffrey Goldsmith, chairman of the department. "Several programs also encourage medical students to consider a rural location as the site for their family practice office and clinic."

The award reflects progress in the state's efforts to draw physicians to rural areas of the state. ■



Student Group Plans Program to Alleviate Primary Care Shortage

According to the American Medical Student Association, a shortage of primary-care physicians has put a crimp in delivery of care to underserved communities and uninsured citizens.

To draw attention to the problem, the AMSA — with help from the U.S. Health Resources and Services Administration — is developing a program for National Primary Care Week, Sept. 27-Oct. 1, on practically every medical school campus.

The Council of Graduate Medical Education has recommended a physician workforce of 50 percent primary-care doctors and 50 percent specialists. Not enough generalists and too many specialists were in training in 1998 to meet the recommended percentages. ■

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100 YEARS AGO

Natural Substances in Treatment

Many of today's medical journal articles and many medical meetings are embroiled in the debate over the use of natural substances in the treatment of patients. This is not a new phenomenon. Reprinted below is an excerpt from the proceedings of the 24th Annual Session of the Arkansas Medical Society held May 10-11, 1899.

Dr. Clegg: It occurs to me that the subject of materia medica has been most woefully neglected in the discussions of this society ever since its existence. It is acknowledged by botanists that the state of Arkansas has the most abundant flora of any state in the Union. It has occurred to me that the medicinal flora of this state has been woefully neglected; that it is not properly developed. If some member of the society can suggest some shape to get the matter before the society, I think it would be advisable.

Dr. Lantorn: Mr. President, I think there ought to be a section on materia medica and therapeutics for our society. We have got one on surgery and gynecology and the practice of medicine. I think if we had a section on materia medica and therapeutics, we would soon investigate this business and get it before us.

Dr. Clegg: Then, if it is in order, I make a motion that a section on medical botany and materia medica be formed for this society.

The motion was seconded. ■

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Holt-Krock Sale Will End 5-Year Storm

By NATALIE GARDNER

Directors of Fort Smith's Holt-Krock Clinic, after enduring a couple of stormy years, are looking forward to a brighter forecast by the end of the summer.

The sale of the clinic to Sparks Medical Foundation, part of Sparks Regional Medical Center in Fort Smith, may close in August. The sale is the community's answer to the war waged between the clinic's physicians and its owner, PhyCor Inc., a physician practice management company based in Nashville, Tenn.

PhyCor Inc. purchased the 77-year-old clinic in 1994, and what followed was a host of contract disputes between many of the clinics' physicians and the PPM. By 1998, many of Holt-Krock's doctors began leaving the clinic, and 38 physicians filed lawsuits against PhyCor over a noncompete clause in their contracts. The contracts did not allow Holt-Krock physicians to leave the clinic and practice in the surrounding area.

To help keep the doctors in the area, Sparks Medical Center began hiring physicians who were leaving the clinic. The medical center agreed to pay the physicians' liquidated damages to PhyCor.

"During that time, there were some serious gaps that occurred and were threatened," said Michael Helm, chief executive officer of Sparks Medical Center. "A five-member OB/GYN practice went to one. We lost the allergy group, dermatology and one neurosurgeon. We continued to hold meetings with the Holt-Krock physicians and PhyCor, but the doctors would no longer work for PhyCor. So it was hire them to stay or they would leave the community."

The hospital has a vested interest in the stability of Holt-Krock since 90 percent of its admissions come from Holt-Krock referrals, Helm said.

What was created was the Sparks Medical Foundation, a division of the medical center that directly employs physicians. In 1998, about 50 out of 130 Holt-Krock doctors left to join the Foundation.

PhyCor eventually sued Sparks Medical Center for interfering in the operation of the clinic. Following a mediation session overseen by William Sessions, former director of the FBI and a former U.S. district judge, the Foundation announced



Jan. 26 that it would acquire the clinic.

"Right now, we're ironing out all the details," Helm said. "It is extremely complex, and we have to make sure to conform to all of the federal requirements."

Terms of the deal were finalized at the end of May; an independent counselor will evaluate the deal by mid-July. Sparks Medical Center board of directors will review and perhaps approve the terms.

When the deal is closed, the Foundation will own 52 Holt-Krock clinics in 11 communities and will employ 132 physicians — 105 Holt-Krock doctors and 27 new ones — and 569 employees.

"The model we have created is the largest, most comprehensive in the state of Arkansas and probably Oklahoma," Helm said. "There are few systems like this that have total integration — clinics, physicians and hospital services."

The Holt-Krock name will no longer be used at the main office, 1500 Dodson Ave. The name can be used by the Foundation's medical practice groups, but only one group — an internal medicine group at the main clinic — has expressed interest in keeping the Holt-Krock name. Fifteen groups will use the Sparks name, while the rest will use a variety of names, Helm said. Before the ownership change, all the practice groups had generic names; now they will all have a brand name.

The deal isn't done, but the entire infrastructure has been in place for a while. Sparks has been handling central office billing since last fall, and has been handling central billing for all doctors since the first of February.

In the Driver's Seat

The new deal will be physician-directed, with an executive council made up of physicians.

Dr. Robert Janes, a general surgeon formerly at the Holt-Krock Clinic and chairman of the Foundation's executive council, left the clinic last fall to join the Foundation.

"The clinic model was no longer working in a way that let the physicians be adequately compensated," Dr. Janes said. "A high percentage of the doctors at the Holt-Krock Clinic contemplated leaving the community. We were given an opportunity by the Foundation to stay here with-

out risk of financial ruin.”

That gesture is what many of the physicians found appealing — to be able to stay in the same community and not be owned by a company that would cut their earnings. The Foundation gives the physicians a guaranteed income and a very active voice in the operation, Helm said.

“They [the doctors] aren’t going to be answering to an investor-owned company, and they will have access to a significant amount of capital to improve their clinic operations,” he said.

For two years, the Foundation’s doctors will have a guaranteed income arrangement. The following two years will be a public service arrangement with no guaranteed compensation. After four years, the physicians will be allowed to go out on their own.

“But we hope that they will want to remain in Sparks Medical Foundation,” Helm said. “In this setup they are rewarded for productivity from Day One, just like in a private practice.”

Moving On

Although numerous benefits are part of the new arrangement, there is mixed reaction among Holt-Krock physicians, Helm said. Some doctors have joined the Foundation, others are with the clinic but quite willing to join the Foundation and a small group prefers to not be part of the Foundation.

“Overall, it’s been very well received,” Helm said. “It has provided these doctors with a stability and a certainty about their practices. They can remain where they have been satisfied and can maintain those important relationships with their patients.”

Josie Decker, administrator of professional and human services and physician liaison for Holt-Krock Clinic, said she and the majority of the clinic’s staff and physicians are glad to be a part of the Sparks network.

“We’ve worked hand in hand with the Sparks Medical Center for years,” said Decker, a 47-year veteran of the clinic. “We’ve not had problems with them. This is the best thing for the physicians, employees, Sparks and the community.”

Dr. John Lange, a urologist and medical director of Holt-Krock Clinic, said the clinic physicians are grateful to Sparks for stepping in and taking on such a huge operation.

“We’re fortunate there’s an organization that could

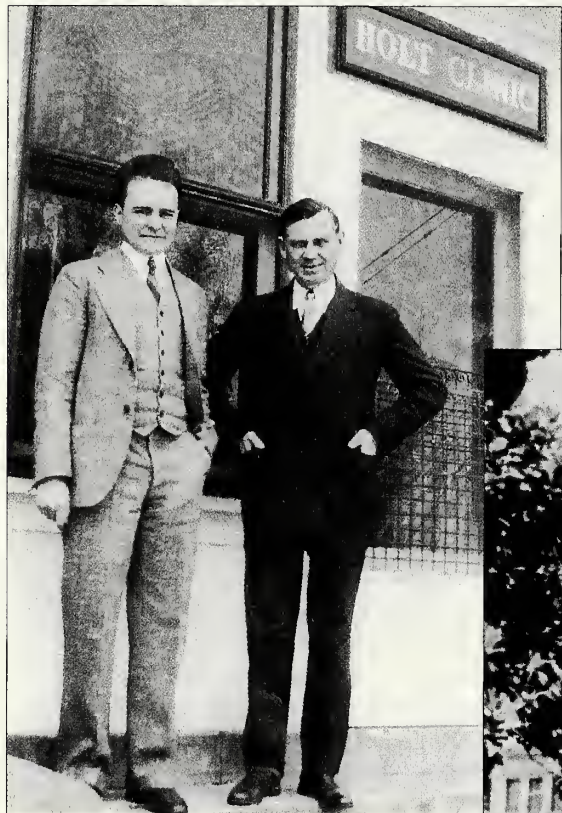
take us in and keep the physician base,” Dr. Lange said. “I know other physicians in similar predicaments and there’s no hospital there to come to the rescue. So, in that way, a lot of the physicians think real positive about Sparks and what they are doing. Even though it’s difficult to lose the clinic, it’s a way to save their medical practices.”

After the ownership change is complete, Dr. Lange will serve as medical director of PremierCare Fort Smith, the physician-hospital organization that contractually joined Holt-Krock Clinic and Sparks Medical Center before the formation of the Foundation. Sparks will take full ownership of PremierCare, and the Foundation physicians will continue to participate in the same insurance plans as in the past, including PremierCare, QualChoice, United HealthCare, Prudential, Medicare Complete and Medicare Assignment.

“One of the advantages of the Sparks deal is that everything will be under local control now,” Dr. Lange said. “With PhyCor, they were out of town, but now all the pieces of the puzzle will be under one roof.”

Dr. Lange said PhyCor wasn’t able to make the practice management part of the deal work, including information systems, billing, collecting and patient satisfaction surveys.

“When we were bought by PhyCor, their physician base increased by 10 to 15 percent,” he said. “They kind of hit the big time when we joined. We weren’t a fire sale, so it was hard to bring us to a



Dr. Fred H. Krock, left, partnered with Dr. Charles S. Holt, founder of the Holt-Krock Clinic, in 1933. Right: The Holt-Krock Clinic in 1952.



better situation. We were already doing well without them."

Over the next four years, the Holt-Krock physicians will be monitoring Sparks' operations, especially where running efficient practices is concerned, Dr. Lange said.

"Many across the country are getting out of managing doctors' offices, but Sparks is going into it," he said. "After four years, these doctors can spin out of Sparks Medical Foundation. That gives them an out, and a lot say they will exercise it if the hospital is losing money on their practice. It will really depend on the level of discipline of the physicians and making sure everyone is coming together and working efficiently."

Sound Advice

Many of the physicians at Holt-Krock Clinic have strong feelings about the PhyCor situation, but many agree PhyCor fulfilled its obligations, just not in a way that fit with the clinic.

"I have no personal ax to grind with PhyCor," Dr. Janes said. "They fulfilled

their contract negotiations. Our goals just weren't aligned, and it wasn't fixable for us. For us, the physicians, it was something whose time had come.

"We just never dreamed this would happen, but it just wasn't possible to practice under those circumstances. It was all financial though; patient care was never a problem."

Dr. Janes said the clinic did its due diligence and there was never a question of whether the deal would work. Since Holt-Krock is a large clinic, its physicians felt PhyCor had something to offer when it came to management.

"We visited a number of their clinics; we hired consultants, lawyers and accountants," Dr. Janes said. "Nothing showed us that it wasn't going to work. Every situation is different. For us, it became so unmanageable because we weren't being compensated properly."

Dr. Lange suggests physician groups looking to join a physician practice management group remain independent if at all possible.

"Establish strong contacts with the

hospital and stay independent as best you can," he said. "You can package everything for your own office and do it more cost effectively. Connect yourself with a larger organization only for things you can't handle, such as joining a network for marketing purposes or using medical records software to help out."

New Beginnings

No one is arguing that the Sparks deal is not good for the community. The relationship between the hospital and the Holt-Krock Clinic dates back 65 years when Dr. Charles Holt, founder of the clinic, closed his private hospital to take over the operation of Sparks during the height of the Depression in 1934.

Now the clinic's physicians and the hospital will be in one system, eliminating duplicate technology and service.

"We can really address the cost of care in this new system," Helm said. "And we can aggressively recruit physicians without the physicians having to worry about a drop in salary by bringing in a partner." ■

National Experts Speak At Colorectal Cancer Symposium

On September 18, physicians from across Arkansas will come together to learn the latest medical breakthroughs in colorectal cancer at the 3rd Annual Charles William Rasco III Symposium on Colorectal Cancer.

Featured speakers include:

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- *Raymond Dubois, MD* - Vanderbilt University
- *Paul Wissel, MD* - GlaxoWellcome
- *Richard Pazdur, MD* - M.D. Anderson Cancer Center
- *Keith Heaton, MD* - UAMS/ACRC/VAH
- *Jean-Pierre Raufman, MD* - UAMS/ACRC/VAH
- *R. Govindarajan, MD* - UAMS/ACRC/VAH
- *Virender Sharma* - UAMS/ACRC/VAH
- *Jillian Evans, Ph.D* - Merck and McGill University

When: Saturday, September 18 - 8 a.m. to 4 p.m.

Where: Sam Walton Auditorium, Arkansas Cancer Research Center on the campus of UAMS in Little Rock

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Meet Our Members

Joseph Beck, MD

By NATALIE GARDNER

HIV Pioneer Stands Up for Patients' Rights

You could call Dr. Joseph Beck, the new chairman of the Arkansas Medical Society Council, a pioneer.

During the 1980s when HIV was just starting to become a major issue, Dr. Beck began treating HIV-positive patients.

"Nobody at that time really was doing it," said Dr. Beck, an oncologist with Little Rock Cancer Clinic. "But I did my fellowship at Bowman Gray in medical oncology, and when I came back to town — I hadn't been in practice very long — a dear friend had a brother-in-law that had the initial manifestations of HIV. She asked me if I would take care of him, and I couldn't resist an old friend, so I did."

Beck's first patient went on to have every known complication of

HIV, which Dr. Beck was seeing for the first time. This first patient was a bartender at a local gay bar and brought many other patients suffering from HIV to Dr. Beck.

"Before long I had this kind of large HIV practice," he said. "And it was either learn about it and take care of the sick people or turn them away and do something else."

Initially, HIV patients made up about 10 to 20 percent of Dr. Beck's practice. Now they are about 50 percent of his practice, with the other half general medical oncology.

At the time when Dr. Beck started treating HIV patients, not much was known about the new disease, which meant he had to be resourceful in getting needed information.

"Luckily, I knew enough to pick up the phone," Dr. Beck said. "So I would call San Francisco General and talk to whoever would talk to me. I actually made several friends who are now way up in things; one is down at the CDC [Centers for Disease Control]. When I didn't know, I asked, and I think that's what every doctor should do."

He also became a regular at AIDS meetings and the International AIDS Conference, gaining



Dr. Joseph Beck, chairman of the Arkansas Medical Society Council, has been treating HIV patients since the disease began to spread in the 1980s.

PHOTOS: SPENCER TIREY

as much knowledge about the disease as possible.

New Patients

Little Rock has a significant HIV population, yet few doctors in the state treat the disease. But more and more patients are coming to these doctors in the early stages of the disease, so they can have treatment.

"The bad part of that is people are still becoming infected nearly 20 years after the mode of infection has been first determined — sex and body fluid and blood transfusions," Dr. Beck said. "So people are still doing sexually risky things; I still have people coming in here who are new infections."

According to the CDC, there are 40,000 new cases of HIV a year.

"So, I don't know if we need more television or less television, but we need to deal with that and do something," he said.

Cost-cutting Challenges

And while treating patients is his major focus, Dr. Beck, as other doctors, is facing challenges in a new managed-care environment.

"My biggest challenge is to provide high-quality care in an era of extreme, and sometimes, inappropriate cost cutting," he said. "That is right now the biggest headache in what I do. Ten years ago, the biggest challenge was, 'Can I stay up intellectually?' Well that pales in comparison now to trying to squeeze the money out of a hospital for certain drugs or certain procedures that they may not think are appropriate."

"It would be very easy to give into the system, and say, 'Mrs. Smith, you're going to have to take second best here because your HMO won't pay for it.' But that's not the oath I took. It's nowhere in the oath that I swear to save money for the

insurance company."

But physicians' problems with managed care can't be fixed without members fighting the fight, Dr. Beck said.

"The biggest problem I see with the Medical Society, and it's a problem shared with medial societies across the country, is members," he said. "There's so many other demands on physicians, people aren't willing or don't have enough time to be involved with the society. The problem with that is if people don't get involved in the society, then we don't have a united voice. The united voice of the lawyers, insurance companies and hospital administrators becomes the voice that policy makers listen to. So my goal is to recruit more members, particularly younger physicians. It's difficult to do, but we have to explain that it may be that the benefits are not immediate, but five years down the road." ■



Clockwise (L-R): Bill Smith, Keith McCullough, Stan Russ, Stephen Chaffin and Jim Strawn.

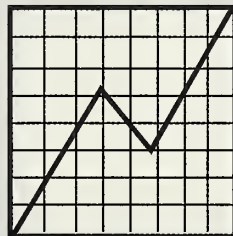
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CARDIOLOGY



Enhanced External Counterpulsation

CHARLES R. CALDWELL, MD

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The treatment of coronary atherosclerosis has changed remarkably in this century. Medical management was the sole treatment prior to advent of coronary artery bypass graft surgery in the mid 1960s. Percutaneous coronary intervention developed nearly a decade later paved the way for a minimally invasive method of coronary revascularization. Coronary stenting, rotational and directional atherectomy, and minimally invasive techniques of coronary bypass graft surgery rapidly followed in the 1980s and 90s. As a new millennium approaches, scientific study is ongoing with vascular endothelial growth factor(s) to promote growth of new vessels, and percutaneous transmyocardial laser therapy to treat patients that are either not candidates for, or refractory to, these earlier forms of revascularization. Another new form of therapy, enhanced external counterpulsation (Vasomedical Inc., Westbury, N.Y.), has emerged as a potential therapy for patients suffering from severe disabling angina. We recently cared for a patient treated with enhanced external counterpulsation with dramatic relief of angina.

Patient Presentation

History, Physical, and Laboratory Examinations

A 63-year-old male was referred with severe substernal chest discomfort,

present at rest and with minimal exertion (Canadian Cardiovascular Society grade IV angina, see table 1, complete problem list). Even routine activities such as shaving, showering and walking were limited and interrupted by angina on a routine basis. He had sustained three prior myocardial infarctions and underwent two coronary artery bypass grafting procedures. He had a permanent cardiac pacemaker. He was taking aspirin, long-acting nitrates, a calcium-channel blocker and an HMG-CoA reductase inhibitor. He took 10-20 sublingual nitroglycerin tablets daily to relieve his chest discomfort. His physical and laboratory examinations were unremarkable.

Treatment

Due to diffuse coronary atheroscle-

rosis, the patient was not a candidate for either percutaneous coronary angioplasty or further open heart surgery. He completed a 35-treatment course of enhanced external counterpulsation therapy over a seven-week period. Enhanced external counterpulsation was performed using a pneumatic cuff on the calves, thighs and buttocks (Fig 1). These cuffs were inflated sequentially from calf to thigh to buttocks with a 50-msec delay during diastole with rapid deflation of all cuffs at the beginning of systole. This increased diastolic pressure and cardiac output and decreased myocardial oxygen demand and cardiac afterload. He had no side effects from therapy and achieved appropriate levels of diastolic to systolic augmentation during treatment. He is now doing well and has very infrequent episodes of angina usually

Table 1. Complete Cardiac Diagnosis

Etiology:	Atherosclerosis
Anatomy:	Severe three vessel coronary disease
Physiology:	A. Placement of a permanent pacemaker B. Pre-EECP: grade IV angina C. Post-EECP: grade I angina D. ETT: exercised 5 minutes (Bruce protocol), 1 mm ST-segment depression
Objective:	Severely compromised
Functional:	Mildly compromised

occurring with only maximal exertion (Canadian Cardiovascular Society grade I angina). Long-acting nitrates have been stopped, and remarkably, he now takes only one to two sublingual nitroglycerin tablets per month. He now walks regularly and enjoys deer hunting, yard work and traveling. On the most recent treadmill exercise stress test he completed five minutes on a Bruce protocol achieving 90% of his age predicted maximal heart rate. He had 1mm ST-segment depression at peak exercise, and the test was terminated secondary to dyspnea. There was no exercise induced chest discomfort.

Discussion

Diastolic Augmentation – History and Physiology

In 1953, Kantrowitz and Kantrowitz related the augmentation of the diastolic arterial pressure to improved coronary artery flow.¹ The intra-aortic balloon pump, developed in the 1960s at the Cleveland Clinic, acutely improves coronary flow, reduces left ventricular work and oxygen demand, reduces cardiac afterload and improves coronary artery patency rates following complex coronary revascularization procedures.^{2,3} The mechanism of long-term improvement seen with enhanced external counterpulsation is related possibly to increased production of vascular endothelial growth factor(s) or the recruitment of existing coronary collateral channels thereby improving coronary collateral circulation.^{4,5}

Enhanced External Cardiac Counterpulsation – Initial Clinical Studies

In the early 1970s, a hydraulically activated external device improved survival in patients with cardiogenic shock.⁶ Additional clinical benefit of external cardiac counterpulsation was noted in the late 1970s when mortality was reduced from 17.5% to 8.3% ($p < 0.05$) in 258 patients with acute myocardial infarction treated with external counterpulsation for three hours within 24 hours of admission.⁷ Since the 1980s, external counterpulsation devices have been extensively used in China to treat angina.⁸



Figure 1. Enhanced external counterpulsation is performed using a pneumatic cuff on the calves, thighs and buttocks. These cuffs are inflated sequentially from calf to thigh to buttocks with a 50-msec delay during diastole with rapid deflation of all cuffs at the beginning of systole. Diastolic blood pressure and cardiac output are increased and myocardial oxygen demand and cardiac afterload are decreased. Long-term benefit is perhaps related to an increase in coronary collateral development due to expression of vascular growth factors.

Enhanced External Cardiac Counterpulsation – Clinical Trials in the United States

In 1995, Lawson reported his experience in 18 patients with disabling angina who received 36 one-hour treatments.⁹ Three years after this initial treatment, 16 of these 18 patients were free of angina or had their doses of anti-angina medications reduced. With radionuclide testing, ischemic defects were completely resolved in 12 patients (67%), improved in two patients (11%) and were unchanged in four patients (22%). Five-year follow-up of the first 33 angina patients treated with enhanced external counterpulsation showed nearly a 90% survival rate and a 60% freedom from death or myocardial infarction.¹⁰

The results of the Multicenter Study of Enhanced External Counterpulsation (MUST-EECP) trial were recently reported.¹¹ One hundred and thirty-nine patients with severe angina were randomized to receive either hemodynamically inactive or active enhanced external

counterpulsation. There was a significant improvement in time to ST-segment depression on a treadmill stress test (active group, pre-treatment 337 ± 18 seconds \rightarrow post-treatment 379 ± 18 seconds, $p < 0.0016$; inactive group, pre-treatment 326 ± 21 seconds \rightarrow post-treatment 330 ± 20 seconds, $p = \text{NS}$). Duration and frequency of angina were decreased with enhanced external counterpulsation. There was a statistical insignificant trend towards less nitrate use in the active counterpulsation group compared to the inactive group. No serious complications occurred in either group. Sustained clinical benefit is seen one year following therapy.¹² Medicare now reimburses enhanced external counterpulsation therapy for treatment of patients with severe angina not amenable to percutaneous or surgical revascularization.

Conclusion

Enhanced external counterpulsation offers promise to improve the quality of life for patients with debilitating angina

not amenable to percutaneous or surgical revascularization. There is ongoing study in patients with coronary disease (including candidates for percutaneous coronary intervention or coronary artery bypass graft surgery and in those with incomplete coronary revascularization) and also those with severe peripheral vascular disease in the cerebral, renal or lower extremity vessels.

References:

1. Kantrowitz A, Kantrowitz A. Experimental augmentation of coronary flow by retardation of arterial pressure pulse. *Surgery* 1953;34:678-687.
2. Mouloupoulos SD, Topaz S, Kolff WF. Diastolic balloon pumping (with carbon dioxide) in the aorta: mechanical assistance to the failing circulation. *Am Heart J* 1962;63:669-675.
3. Harken DE, Soroff HS, Birtwell, WC. Assisted circulation: counterpulsation and coronary artery disease. *Surg Ann* 1972;4:165-189.
4. Soroff HS, Birtwell WC. Clinical evaluation in synchronous counterpulsation in cardiogenic shock. *J Cardiovasc*

Surg (Torino) 1973;752:752-756.

5. Amsterdam EA, Banus J, Criley JM, Leob HS, Mueller M, Willerson JT, Mason DT. Clinical assessment of external pressure circulatory assistance in acute myocardial infarction: report of a cooperative clinical trial. *Am J Cardiol* 1980;45:349-356.

6. Zheng ZS, Yu LQ, Cai SR, et al. New sequential external counterpulsation for the treatment of acute myocardial infarction. *Artif Organs* 1984;8:470-477.

7. Lawson WE, Hui, J, Burger L, et al. Three-year sustained benefit from enhanced external counterpulsation in chronic angina pectoris. *Am J Cardiol* 1995;36:840-841.

8. Lawson WE, Hui J, Zheng ZS, et al. Five-year follow-up of morbidity and mortality in 33 angina patients treated with enhance external counterpulsation. Presented AFMR Biomedicine 97 Session 4/97. *J Invest Med*. 1997;45:212A.

9. Arora RR, Chou TM Jain D, et al. Results of the Multicenter Study of Enhanced External Counterpulsation (MUST-EECP): enhanced external counterpulsation reduces anginal episodes and exercise-induced myocardial ischemia (ab-

stract). *Circulation* 1997;96:1-466.

10. Arora, RR, Chou, TM, Jain D, et al. Results of the Multicenter Enhanced External Counterpulsation (MUST-EECP) outcomes study: Quality of life benefits sustained twelve months after treatment (abstract). *J Am Coll Cardiol* 1999;33:339A.

11. Arora, RR, Chou, TM, Jain D, et al. Results of the Multicenter Study of Enhanced External Counterpulsation (MUST-EECP): enhanced external counterpulsation reduces anginal episodes and exercise-induced myocardial ischemia (abstract). *Circulation* 1997; 96:1-466.

12. Arora, RR, Chou, TM, Jain D, et al. Results of the Multicenter Enhanced External Counterpulsation (MUST-EECP) outcomes study. Quality of life benefits sustained 12 months after treatment (abstract). *J Am Coll Cardiol* 1999; 33:339A. ■

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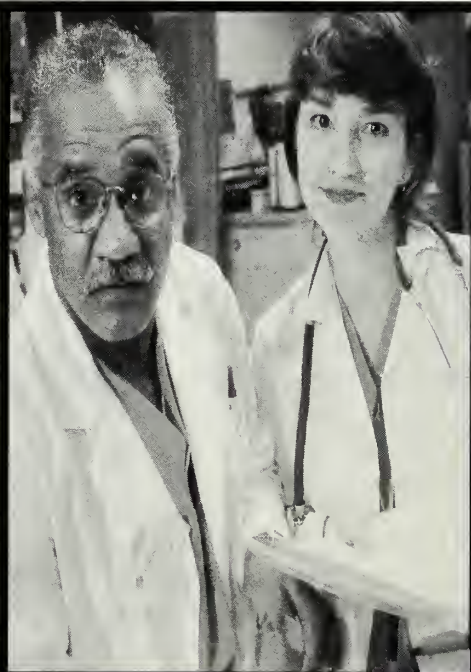
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Beta Blocker Treatment Following Acute Myocardial Infarction: An Effective but Underutilized Intervention

WILLIAM E. GOLDEN, MD
ROBERT H. HOPKINS, MD

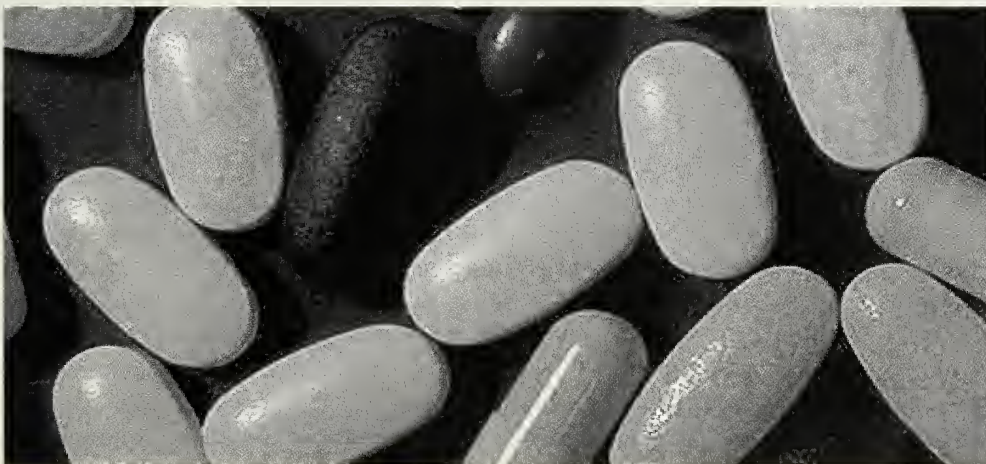
For the past six years, the Arkansas Foundation for Medical Care, Inc. (AFMC), Health Care Quality Improvement Program (HCQIP), has focused primarily on inpatient projects. In 1996, we began expanding project information to include outpatient issues. Earlier ambulatory topics included management of thyroid disease, diabetes and flu immunization.

This AFMC project focuses on the prevalence of facility resources to manage hypertension and asthma as part of quality improvement efforts for Medicare and Medicaid patients in Arkansas. AFMC understands that outpatient facilities frequently lack an infrastructure to conduct outpatient chart audits in an efficient and effective fashion. This difficulty in data acquisition reflects a significant barrier. Nevertheless, certain processes and structural elements can be assessed to improve management of common outpatient conditions.

Cardiovascular disease remains the major cause of mortality in this country. Impressive advances in invasive cardiac procedures plus increased public attention to diet, smoking cessation and exercise have resulted in sustained reduction in the national cardiovascular death rate. Nevertheless, additional progress could be achieved if we consistently applied lessons learned from clinical trials.

Aside from aspirin and other platelet

inhibitors, beta blockers are the only class of cardiovascular drugs that has been shown to reduce second myocardial infarctions and improve survival post myocardial infarction. Practice guidelines developed by the American College of Cardiology/American Heart Association, the American Academy of Family Physicians and the American College of Physicians all highlight the use of beta blockers as an important intervention.^{1,2,3}



Treatment of patients with beta blockers following myocardial infarction has been identified as a core indicator for good cardiovascular care and is now being measured by health care payers and in quality improvement teams.

Use of beta blockers after discharge for myocardial infarction has been demonstrated to improve long-term survival by as much as 40%.⁴ Calcium channel blockers, to this point, have not been demonstrated to reduce mortality post myocardial infarction.

In the early 1990s, the National Cooperative Cardiovascular Project (CCP) reviewed the management of more than 115,000 Medicare beneficiaries with acute myocardial infarction. State rates varied from 30.3% to 77.1% in the prescription of beta blockers to patients who had no identifiable contraindications to the use of these medications.⁵ Arkansas fell into the group of states with the lowest rate of beta blocker use.

Prescribing beta blockers for more Arkansans following initial cardiovascular events could reduce our state's high rate of cardiovascular morbidity and death. Treatment of patients with beta blockers following myocardial infarction has been identified as a core indicator for good cardiovascular care and is now being measured by health care payers and in quality improvement teams.^{6,7,8}

As a result of AFMC's statewide efforts in the CCP project, and other factors, prescription of beta blockers after infarction has increased nearly 60 percent from the initial assessment. Clearly, however, there is still room for improvement as more than half the ideal patients do not yet receive this medication after discharge for infarction.

What is the reason for this underuse? Beta blockers lack charisma. This class of medication has been available for many years. Several effective compounds are available in generic formats and therefore do not receive promotion by the pharmaceutical industry. Other medications that cost more and deliver fewer benefits in terms of cardiovascular survival receive greater attention because of corporate marketing practices. The side effects of beta blockade are frequently overstated and

poorly documented in the medical literature. Thus, it is important for all clinicians who treat patients with established cardiovascular disease to reassess their use of beta blockade in the proper management of this common condition.

Several key concepts about beta blockade and heart disease deserve emphasis:

1. *Beta blockers should be given intravenously in the immediate management of most patients with acute myocardial infarction.* Intravenous beta blockers should be administered within the first 12 hours of acute myocardial infarction in the absence of hypotension, bradyarrhythmias, hypersensitivity or moderate to severe left ventricular failure.¹ Beta blockers have been demonstrated to limit the size of the infarction and reduce short term mortality with and without concurrent revascularization.

2. *Beta blockers should be continued long-term following myocardial infarction.* Patients at high risk for recurrent myocardial infarction are the most likely to benefit from chronic treatment with beta blockers. The data on mortality reduction is strongest for patients with prior q-wave infarction but is also present for patients without evidence of transmural injury. Beta blockers have also been demonstrated to morbidity and mortality in many patients at low risk of reinfarction and in patients at high risk of reinfarction who have certain traditional contraindications. Patients at greatest risk of reinfarction have the following attributes: advanced age, anterior infarction, complex ventricular ectopy left ventricular systolic dysfunction. In the absence of specific contraindications, beta blockers should routinely be prescribed in these patients.

3. *Many patients previously considered to be "poor candidates" may be treated safely with beta blockers.* The

relative contraindications to beta blocker use include: asthma and severe COPD, peripheral vascular disease, moderate or severe left ventricular failure, insulin dependent diabetes mellitus, PR interval > 0.24 seconds, second or third degree heart block, systolic blood pressure < 100 mm Hg or heart rate < 60 beats per minute.¹ A recent retrospective review suggests that many patients with these "contraindications" also will benefit from reductions in mortality when treated with beta blockers following myocardial infarction.⁴ In patients with complex medical histories, the ultimate decision on beta blocker use must be made on a case-by-case basis; and expert consultation may be valuable. Careful dose titration may facilitate the use of beta blockers in these patients. Recent studies have demonstrated no significant impact on quality of life with beta blocker use in patients with coronary disease.⁹

4. *Calcium antagonists, unlike beta blockers, are not first-line agents in patients with myocardial infarction.* Calcium antagonists are commonly prescribed in patients with coronary disease. There are no data to demonstrate reduction in mortality with the use of calcium antagonists after acute myocardial infarction; in MI patients with left ventricular dysfunction or pulmonary congestion, data indicate these medications could be harmful.¹ Short-acting nifedipine is specifically contraindicated in patients with acute myocardial infarction. Expert consensus believes that calcium channel blockers are used excessively in patients with acute myocardial infarction to the exclusion of more valuable beta blocking agents.^{1,4}

In summary, beta blocker treatment has been proven to reduce morbidity and mortality in most patients following myocardial infarction. Beta blockers may be used without significant complications or negative quality of life effects in many patients

considered in the past to be suboptimal candidates. Despite practice guidelines recommending beta blockers in patients following acute myocardial infarction, they are underutilized in the United States, including Arkansas. Greater appreciation of this relatively inexpensive medication could improve health of Arkansans with heart disease. ■

Bibliography

1. Ryan, TJ, Anderson JL, Antman EM, Braniff BA, et.al. ACC/AHA guidelines for the management of patients with acute myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Acute Myocardial Infarction). *J Am Col Cardiol* 1996; 28:1328-1428.

2. Health Science Communications, Inc.; Grauer K, Clark DS, Ruoff

GE, consultants. Cardiovascular disease: update on management of heart failure, acute myocardial infarction, and cardiac arrhythmias. American Family Physician Monograph No. 1, Kansas City, MO: American Academy of Family Physicians; 1998.

3. Guidelines for risk stratification after myocardial infarction. American College of Physicians. *Ann Int Med* 1997; 126(7):556-560.

4. Gottlieb SS, McCarter RJ, Vogel RA. Effects of beta blockade on mortality among high-risk and low-risk patients after myocardial infarction. *NEJM* 1998; 339: 489-497.

5. Krumholtz HM, Radford MJ, Wang Y, Chen J, et.al. National use and effectiveness of beta blockers for the treatment of elderly patients after acute myocardial infarction. *JAMA* 1998;280:623-629.

6. Wang TJ, Stafford RS. National patterns and predictors of beta blocker use in patients with coronary

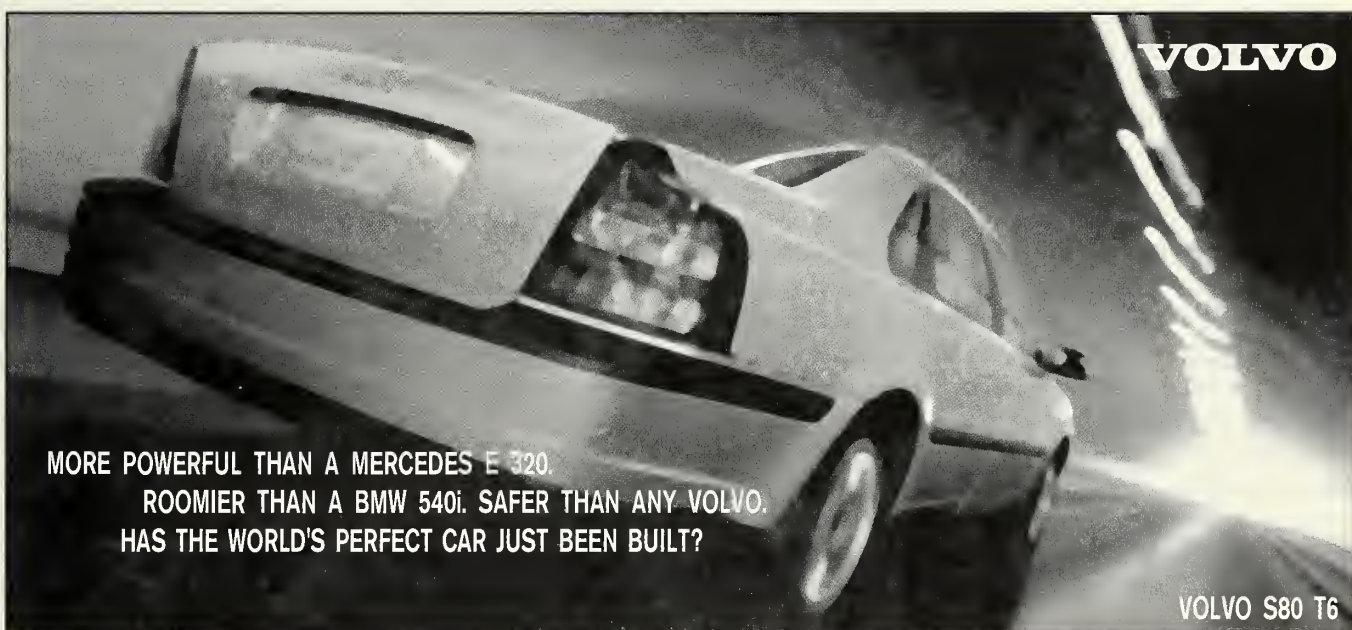
artery disease. *Arch Int Med* 1998; 158:1901-1906.

7. Barron HV, et.al. Beta blocker dosages and mortality after acute myocardial infarction: data from a large health maintenance organization. *Arch Int Med* 1998;158:449-453.

8. Mendelson G, Aronow WS. Underutilization of beta blockers in order patients with prior myocardial infarction or coronary artery disease in an academic, hospital-based geriatrics practice. *J Am Geriatrics Soc* 1997;45:1360-1361.

9. Dahlof C, Dimenas E, Kendall M, Wiklund I. Quality of life in cardiovascular diseases: emphasis on beta blocker treatment. *Circulation* 1991;84(6suppl):VI108-VI118.

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Human Resource Strategy in a Medical Office: A Source of Competitive Advantage

BY JAMES A. TANNER, MD

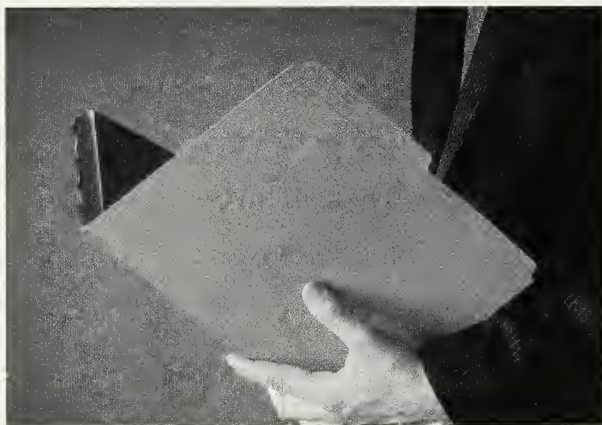
Most small medical offices have never considered a "human resource strategy." Many physicians fail to recognize the competitive advantage they can obtain from their office staff.

The cost of low morale, training a new employee and lost productivity from staff turnover is often never considered. Increasing competition and emphasis on patient satisfaction have required many physicians to reevaluate their office management and routines. Here are three simple strategies for human resource management that can be adopted by any small medical office.

Developing a Competitive Edge

Most physicians have never assessed human resource practices as a critical element of their office management. Like most small business owners, physicians tend to view their "core competency" as their product or service, ignoring the people that actually deliver that product or service. Human resource management has been "by the seat of the pants" or "crisis management" rather than a well-planned strategy to provide a competitive advantage.

Medical practice has become much more competitive in the last decade. Small individual practices have merged. Large, multispecialty groups have become common. Profits and incomes have dropped because of "managed care" and lowered contracted reimbursement rates. Physicians have now begun to look



for management efficiencies and sources of competitive advantage other than their direct services. Human resource management, however, has often been the last place to look for these efficiencies and advantage. Most physicians view HR management simply as the salary and benefits package. As hard as physicians try to understand and manage diseases of the mind and body, they will ignore the pathology of the dysfunctional workplace.

Why is human resource management critical even for small businesses, and how can this provide competitive advantage?

- Employees can greatly increase or severely limit effectiveness.
- Employee turnover is expensive, disruptive and lowers office productivity.
- Improper selection and personnel decisions can create legal exposure.

The personnel management processes of employee screening and selection, employee retention and performance appraisal need to be addressed.

Physicians who have never considered modern human resource management practice as a source of competitive advantage should consider the following guidelines.

Employee Screening and Selection

Practice management consultants often say the most critical employee in a medical office is the least trained, the least paid and the least permanent. This, of course, is the medical receptionist. This one person is the first contact with a patient in the office, often controls access to the physician by way of appointments and telephone calls, and must handle patient complaints with skill and finesse. Yet how careful is the selection process for this critical position?

Can you imagine a dyslexic extroverted file clerk? Have you ever hired a charming attractive typist that interviewed well, only to find out she couldn't type? What about a nurse that can't seem to get along with others, seems chronically depressed and seems insensitive to the needs of patients in distress? Mistakes such as these are costly in terms of office morale, rehiring and training costs and patient dissatisfaction. How can these mistakes be avoided?

Step 1: Job Analysis and Job Description

Each applicant needs a clear understanding of the duties and responsibilities of a job. This will enable the appli-

cant to evaluate his suitability for the job and the employer to identify the major performance issues that determine the hiring criteria and future performance evaluations. A telephone interview concerning the job description and requirements will screen some applicants before future interviews are set. Those applicants that meet basic criteria are invited to complete an application form.

Step 2: Biographical Information and Application Form

The purpose of the application form is to organize résumé information into a consistent comparable format. Application forms should be constructed so they do not request discriminatory information. The form should evaluate three questions:

1. Does the employee have the necessary education and experience?
2. How has the applicant's career progressed?
3. Does the applicant have a stable work record?

Step 3: Structured Interview

The unstructured employment interview is of questionable value and may expose the employer to violations of various equal opportunity laws. Casual questions about family, church affiliation and health status may be found discriminatory if the applicant is not hired. The interview may be used to assess interpersonal and communication skills, physical presence, appropriate dress and demeanor and motivation. A structured interview may be used to assess how an employee would respond to various situations. For example, "Mary Smith, a new patient, shows up on the wrong day for her appointment. The doctor is already behind schedule due to an unexpected emergency. How should Ms. Smith be managed?" All applicants' responses may then be evaluated against appropriate standards.

Step 4: Testing

Testing can be used to assess job-relevant psychological traits and abilities. Many employers do not use tests fearing

they are illegal, ineffective, expensive or difficult to administer. Appropriate testing, however, can be the most valid component of the selection criteria.

Several simple tests can be administered in less than 30 minutes at a cost of under \$25. The most common is the Wonderlic Personnel Test. It is used to identify applicants who learn quickly and can be fast and accurate with both number- and word-oriented tasks. The Name-Finding Test can be used to test short-term memory and attention to detail.

The Hogan Personality Inventory is a measure of normal personality. It is designed for use in personnel selection, individualized assessment and career-related decision making. It provides detailed information regarding what we call the "bright side" of personality characteristics that appear in social interaction and that facilitate or inhibit a person's ability to get along with others.

A standardized typing/word-processing test can easily be administered to assess skills for a clerk typist. Certain jobs (payroll clerk) may require specific skills and knowledge that can be evaluated with specific job knowledge tests.

Drug testing may be indicated in medical office situations because of the access to controlled substances.

The best defense against discrimination claims regarding pre-employment testing is the selection method's job relevance, validity of the test and equal application of the test. For this reason in small offices, it is best to use commercially available standardized tests with proven validation that are appropriate for the job description. Pre-employment drug screening is legal if equally applied to all candidates.

Step 5: References

References from previous employers should be a valuable tool in employee evaluation. However, past employers may have strong motivations to withhold critical information. They may be fearing a defamation tort or attempting to avoid an unemployment insurance claim. They may be getting rid of a

troublemaker and agreed to give a good reference as part of a deal for resignation. They may be trying to help a friend or relative. Smart managers will avoid giving references over the telephone, especially unfavorable ones. However, careful listening and appropriate questions may illicit valuable information. All references should be contacted and evaluated.

Employee Retention

Unlike large corporations, job advancement is limited in small businesses. The receptionist is unlikely to have a natural job progression to office manager. A small business must establish innovative ways to retain and motivate good employees with little hope for job advancement.

In his book, "The Motivation to Work," psychologist Fredrick Herzberg described "hygiene factors" that contribute to job dissatisfaction, but not to job motivation. Such factors include organizational policy, supervisor relations, work conditions, peer relationships and job security. These fundamental factors must be satisfied before ever hoping to achieve superior performance. Salary alone is not a motivating force. The salary and benefit package must be perceived as equitable but is often considered an entitlement, not a motivation.

In a medical office, the strongest motivating factor is often a sense of fulfillment from helping people in need. Additionally, achievement, recognition, responsibility and personal growth motivate most employees.

A human resource strategy must address these factors to retain a highly skilled staff.

• **Organizational Policy Review** — Many small medical offices do not have formal "policy and procedure" manuals or even written job descriptions. This causal system invites job dissatisfaction and potential legal liability. Most medical offices are aware of the strict Occupational Safety and Health Administration exposure control standards but are unaware of the need for sexual harassment policies. Compliance to written policies is essential to avoid allegations



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• **Human Relations Training** — Medical office managers are very skilled in insurance claims, office administration and conflict resolution with patients but have little or no formal training in dealing with the emotional needs of the staff. Just as the receptionist is critical to patient satisfaction, the office manager is critical for employee morale. How many office managers view this aspect as part of their job description? Appropriate staff development programs should emphasize human relations training.

• **Salary and Benefit Review** — An annual survey should be conducted to assess the equity of salary and benefit packages. Many employees will work for a lower pay and benefit package if the job environment is superior; however, all employees must feel their salary is equitable compared with other employers.

• **Recognition and Achievement** — Even the smallest office will have a corporate culture. It is the responsibility of the manager or owner to ensure that part of this culture is recognition of the achievements of each employee. These achievements can be both personal and professional.

• **Responsibility and Job Enrichment** — Job satisfaction and retention of the best employees will come from job enrichment. Every job can be "enriched" if the employee is given responsibility, appropriate goals, encouragement and timely feedback.

Performance Appraisal

A regular performance appraisal is often forgotten or ignored in many small businesses, including medical practices. It is often very uncomfortable for both the employer and employee. Without structure, a poorly conducted performance appraisal can harm the self-esteem of the employee, increase dysfunctional behavior and expose the employer to litigation. A properly executed performance appraisal is an opportunity to enhance motivation, improve productivity and provide legal protection by adequate documentation of performance problems. The most common causes of dissatisfac-

tion with the appraisal system are lack of objective measurement standards, rewarding seniority instead of performance and the failure of management to devote sufficient time for the evaluation.

An employee must regard the performance appraisal as fair. A prerequisite of any evaluation is a comprehensive job description. An employee must know what performance is expected. The evaluation should not be based on subjective feelings but on actual behaviors, known as Behavior Based Performance Standards (BBPS) and rated on a Behaviorally Anchored Rating Scale (BARS). Any behavioral deficiencies should be discussed, documented, and action plan developed. A specific time for corrective action should be given.

The employee should be given the opportunity to discuss any concerns, and job enrichment strategies should be explored. Many systems also include peer reviews and give the employee an opportunity to evaluate their supervisor and employer. Similar to the job interview process, the performance appraisal should be structured and well planned as a motivation and job enhancement technique.

Conclusion

The processes of employee screening and selection, employee retention and performance appraisal are basic to effective human resource management. A structured strategy can enhance office productivity, reduce hidden costs, reduce legal exposure and promote the quality of and efficiency of medical care. ■

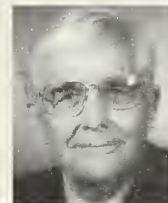
Dr. Tanner is a gynecologist with the Arkansas Women's Center in Little Rock.

References:

- F. Hertzberg, B. Mausner, and B. Snyderman, "The Motivation to Work" (New York: Wiley, 1959).
- Hogan Assessment Systems, P.O. Box 521176, Tulsa, Okla., 74152
- Solomon, Robert J. "The Physician Manager's Handbook" (Maryland: Aspen Publishing, 1997).
- Wonderlic Personnel Tests Inc., 820 Frontage Road, Northfield, Ill., 60093. www.wonderlic.com/

Old Past History Critical

J. KELLEY AVERY, MD



A 53-year-old obese man who worked in a factory and was on his feet most of the time saw his family doctor for three days of severe pain low in the right side of his chest posteriorly, just above his costovertebral area.

The pain was described as a pleuritic type of discomfort that was worse on deep inspiration. He had some nausea and vomiting but denied any dysuria or blood in the urine. He had no cough. He had a history of sickle cell trait. He gave a history of a similar episode years before on the left side of his chest but did not know whether or not the physicians ever found its cause.

On his initial evaluation by his primary care physician his weight was 210 lb., blood pressure 108/60 mm Hg and temperature 101.8°F. He was slightly icteric, and had moist rales over the base of his lung field posteriorly. His liver was enlarged to percussion, the margin being about 8 cm below the costal margin. There was some tenderness over the right paravertebral area, which the examiner thought was hepatic. The urine sp gr was 1.011, pH 8.5, and microscopic findings were negative. The hemoglobin was 11.3 gm/dl, hematocrit 34.8%, WBC count 15,600/cu mm with 68% segmented neutrophils, and 32% lymphocytes.

The smear showed some large RBCs with target cells and possible sickling. The chest X-ray was interpreted by the examiner as consistent with bilateral basilar pneumonia, and the radiologist's report read, "Bibasilar atelectases and/or infiltrates are seen. The heart, pulmonary vasculature, mediastinum, and upper lungs are normal." The working diagnosis was pneumonitis, for which he was given tetracycline and asked to return in three days.

The following day, when he was called about the chest X-ray, he said that he felt a little better. The blood drawn the day before was reported as showing elevated liver function tests and a bilirubin of 1.5 mg/dl. He continued to have pain and a codeine preparation was prescribed.

Three days after his first visit he returned as instructed. His temperature had been normal that morning at home and was recorded at 99.5°F in the office. His antibiotic was changed to erythromycin, and tests for cold agglutinins and mycoplasma antibodies and

a WBC count were ordered. The blood smear was essentially unchanged and the mycoplasma titre was reported as positive.

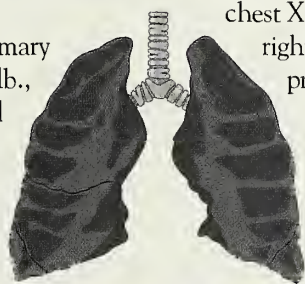
He was then admitted to the community hospital with the same history, adding that he had not spit up any blood. His physical examination was reported to show reduced to absent breath sounds in the right base posteriorly. He was said to be very angry about not having been admitted to the hospital at the onset of this episode. The laboratory studies, in addition to arterial blood gases, were within normal limits and the liver enzymes remained elevated. The chest X-ray revealed, "extensive infiltrate in the right base," and the admitting diagnosis was pneumonia, for which he was treated with IV erythromycin and Rocephin.

For the next four days he remained essentially unchanged. He continued to have pain in his chest and fever and was described by his primary-care physician as "getting weaker." A consultant, a specialist in internal medicine and cardiology, was called for his opinion and management of this difficult patient. Noting the bilateral lung findings and the elevated liver enzymes, he thought there was probably multiple organ involvement by an infectious disease as yet not identified.

The antibiotic treatment was stopped, and over the next three days in the hospital he was said to be much improved. Repeat blood studies showed negative cultures, negative Sickledex test and no change in the appearance of the chest X-ray. He was discharged home, to return to his consultant's office in a week for follow-up.

On his return, the chest X-ray showed some improvement in the aeration of the left base, but in the right base there was the suggestion of a mass, and the elevation of the liver enzymes was increasing. With plans for a bronchoscopy and biopsy by a thoracic surgeon, the patient refused hospitalization and went to see a different physician three days later.

The evaluation was repeated, with no change in findings, and again a neoplasm of the right lung was the primary consideration. The bronchoscopy/biopsy was scheduled by the different team of physicians, but when no definitive diagnosis resulted from these procedures, plans were made for an open biopsy or resection of the lesion in the right lung. For family



The laboratory studies, in addition to arterial blood gases, were within normal limits and the liver enzymes remained elevated. The chest X-ray revealed, "extensive infiltrate in the right base."

considerations, the patient had to be discharged to return as soon as possible.

Four days later he was readmitted to the second hospital for an open thoracotomy. On the morning of admission he complained of pain in the left posterior chest similar to the pain he had experienced on several occasions previously. The readmission examination showed no change. The heart was said to show no murmurs or arrhythmias, and the lung fields continued to show the basilar rales. The history of his experience in the other hospital and with the other physicians was obtained from the patient and the chart noted, "No previous chest X-rays are available for review."

The open biopsy was done, and the pathologist reported that the lesion was a hemorrhagic infarct of the lung. Within hours of the surgery the patient developed cardiopulmonary arrest, was resuscitated and lived for about two weeks. During this time his lungs were studied for perfusion defects consistent with the clinical impression of pulmonary embolism. Autopsy showed multiple pulmonary infarcts of varying age, and a thrombotic lesion in the right atrium of the heart was thought to be the source of the multiple pulmonary emboli that led to his death.

A lawsuit was filed charging both the original internist and the thoracic surgeon who was called in by the second physician with negligence in failing to conduct the proper studies and failure to administer the proper treatment for the patient's disease, which led to his death.

Loss Prevention Comments

It was the opinion of the claims committee on two different reviews that there was no deviation from an acceptable standard of care in this case. It was pointed out that the diagnosis of recurrent pulmonary emboli without any evidence of a source is very difficult, and is not infrequently missed. A number of concurrent facts confused the picture. The history of sickle cell disease was confusing, and a Sickledex test during his illness was negative. There were no autopsy findings consistent with this diagnosis. The findings on chest X-rays were interpreted repeatedly by the radiologist as consistent with

pneumonia. The WBC count was elevated, and mycoplasma antibodies were present. There seemed to be some response to antibiotics given by the second medical specialist to whom he went on his own referral. On the other hand, this was a 53-year-old man who was otherwise healthy and working every day, who became ill, was treated by good physicians and was dead in about six weeks.

During the investigation of this case after the lawsuit was filed, the records from the hospital where this man was treated for a similar episode 25 years earlier were obtained. Again there was severe chest pain, and chest X-ray findings were consistent with pneumonia that resolved very slowly despite treatment. The suggestion made on summary of his case at that time was that the episode was consistent with pulmonary embolism with a resulting infarction, which accounted for the slow resolution of the chest findings.

It was not until the autopsy revealed the thrombus in the right atrium of the heart that the picture was complete. Should the physicians have considered pulmonary embolism and done studies to confirm it? It is easy in retrospect to say they should have. However, there was no suggestion of deep vein thrombosis in the extremities to point to the correct diagnosis, there was no hint of cardiac disease that would have suggested the atrial thrombosis, and the evaluation of the heart on physical examination and X-ray was consistently normal.

In looking carefully for contributing factors that might have led the doctors "down the primrose path," there are some that should serve as reminders to all of us. First, there was the patient's own contribution to the outcome. He left the doctors who had looked at him

During the investigation of this case after the lawsuit was filed, the records from the hospital where this man was treated for a similar episode 25 years earlier were obtained.

event.

Did the physicians contribute in any way to the outcome? Again, in retrospect, we would say the first team should have asked for the records of the previous hospitalization 25 years earlier, where pulmonary infarction had been suspected. We would have to say that the two teams of physicians should have communicated with each other, shared diagnostic studies and collaborated in the treatment of this man. These are clinical realities that we wish would never be repeated, but being human, we know that they will. This failure to communicate doctor to doctor in this case should remind us all that we share a common responsibility for patient care even when the patient leaves us and is accepted by another colleague.

These facts, and the very damaging testimony of an expert witness, made a settlement the best course of action in the resolution of this claim. It is interesting that the settlement was made on behalf of the initial internist and the thoracic surgeon called in by the second medical specialist. ■

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the Journal of the Tennessee Medical Association in May 1998. It is reprinted with permission.

carefully for three weeks and chose another doctor. Had he gone through with the investigation as planned by the first specialist — thereby obviating the second specialist having to start from the beginning — would the correct diagnosis have been made and appropriate treatment begun? It is a distinct possibility that it would. Both teams of physicians are good doctors. There is reason to believe that, given a sufficient chance, the correct diagnosis would have been made about three weeks before his terminal



Plane Crash Tests Skills of Local EMS Providers

By NATALIE GARDNER

Getting a call in the middle of night is not unusual for an emergency room physician. So when Dr. Marvin Leibovich, medical director of the emergency department at Baptist Medical Center, got a call late June 1, he wasn't expecting what he heard on the other end of the line.

"The hospital called me — I had already gone to bed and was asleep — just to let me know our internal disaster plan, a Red Alert, had been issued. There had been a crash out at the airport and they were expecting multiple casualties."

While Dr. Leibovich was getting ready to go to Baptist, he received another call from the Little Rock Police Department. Dr. Leibovich, also a Little Rock police officer, was asked to come to the scene and help with the many seriously injured.

Even though Dr. Leibovich has been involved with many disasters through the years, including January's tragic tornado, he wasn't ready for what he saw at the Little Rock National Airport.

American Airlines Flight 1420 crashed during a severe thunderstorm. Broken in half, the jet slid off the runway toward the Arkansas River. The crash killed 11 and seriously

The scene
of the crash
of Flight
1420 was
not hopeful,
but out of
145 on
board, 11
died.

injured several.

"When I got there, there was already a sea of red lights from rescue personnel," Dr. Leibovich said. "The plane was off the approach way of the runway, badly mangled and broken in sections. There was a fire that had just been extinguished. All around were these colored tarps, signifying the different levels of injuries."

Although most of the seriously injured passengers had been triaged and evaluated when Dr. Leibovich arrived, rescue personnel continued searching the site looking for any passengers that might have been ejected from the plane.

"There was an excellent lighting system in the plane, but if you stepped a few feet away from the plane, you were in total darkness," he said. "That and the torrential downpour made it difficult."

Dr. Leibovich helped with the 40-50 people with minor injuries. They were quickly taken to nearby hospitals.

Lessons Learned

Planning was the key to successful

implementation of the disaster plan. Working together, hospital staff, police, firefighters and paramedics got injured passengers the help they needed quickly, Dr. Leibovich said.

"We could learn a lot from the lessons of this tragedy," he said. "Had it not been for planning, things could have been a whole lot worse."

Quicker notification about the disaster to emergency medical service providers and area hospitals could have assisted emergency response, Dr. Leibovich said.

"But overall things were handled very well, and there were no lives lost because of a delay," he said.

Preparing for Disaster

Little Rock's last plane crash occurred almost 10 years ago when an Eastman Kodak corporate jet crashed with seven on board. Yet, American Airlines Flight 1420 had 139 passengers. Even so, health care providers and rescue personnel were ready.

The airport is required to schedule a

disaster drill every three years, which includes participation from city EMS providers. Area hospitals are required by their certifying agencies to conduct internal disaster drills twice a year.

"Fortunately, all hospitals implemented their internal disaster plans," Dr. Leibovich said. "At our hospital there was an excellent response. Trauma surgeons were all in, orthopedic surgeons were here waiting on patients, and we had excellent response by emergency nursing staff. Administration was extremely supportive of us. And talking with other hospitals and physicians, they all had a good exercise."

"It was very fortunate, in this particular aircraft accident, that there had been a degree of deceleration before impact occurred. Had that impact occurred initially, most of the people would have died in that crash. We were very fortunate, that unlike other crashes with 75 or so critical patients, we didn't have that many and we were able to keep up with the injuries." ■

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419A Plans Offer Physicians More Than Tax Deductions

BY WILLIAM E. MAGEE, CPA
BAIRD, KURTZ & DOBSON
LITTLE ROCK, ARKANSAS

Why is there so much discussion in the medical community regarding the benefits of 419A plans? Because a properly structured 419A plan enables a clinic to deduct, for federal income tax purposes, the premiums paid for life insurance that fund the owners' estate taxes or buy/sell agreement.

The plan can cover selected individuals (there are no ERISA non-discrimination rules), and, through the use of life insurance products, plan assets can grow on a tax-deferred basis.

However, an often-overlooked use for 419A plans is to supplement a physician's cash flow during his/her retirement years. Before exploring this opportunity, it is necessary to first develop an understanding of what a 419A plan is and how it operates.

History of the 419A

Prior to 1984, companies could deduct ordinary and necessary costs incurred in providing welfare benefits to their employees. Such benefits include death benefits, severance pay and other items (but do not include deferred compensation or qualified retirement benefits). The covered employees did not have to report the corresponding income on their income tax returns until they actually received it.

Congress decided in 1984 that companies were abusing these deductions, often paying for and deducting the costs many years before employees received and paid tax on the related benefits. To stop these perceived abuses, Congress enacted 419A IRC to place limits on tax deductions associated with providing such benefits.

However, an exception to the limi-

tations was provided for contributions to a multi-employer plan. A multi-employer plan is defined as a plan in which 10 or more employers participate, no employer contributes more than 10 percent of the costs of the plan, and there is no "experience rating" that affects participating employers' costs of providing the benefits. This is usually easily accomplished, since multi-employer trusts have been established, with several hundred employers participating, to accommodate 419A plans.

Consequently, an opportunity continues to exist today to currently deduct amounts paid to a properly structured 419A plan to fund death benefits on behalf of the owner/employees. This opportunity exists even though the covered owner/employees may never pay income tax on amounts in excess of the relatively insignificant PS 58 costs of the insurance, and the plan can be structured so that the related death benefits are not taxed in the owner/employees' estates.

A Typical Example

One of the ways in which a 419A plan can benefit physicians who are approaching retirement is to provide or supplement the physician's cash flow during retirement years. Consider the following example.

Dr. Smith is 53 years old and is a 33 percent owner of a clinic along with two other physicians. He has a modest amount accumulated in his clinic's qualified profit-sharing plan. He plans to retire within the next several years and would like to enhance his cash flow during his retirement years.

In order to provide enhanced welfare benefits to the owners of the clinic, the clinic adopts a 419A welfare benefit plan. The plan provides that the clinic will pay the costs of providing \$2 million of death benefits for each physician/owner of the clinic.

The clinic pays (and deducts) amounts sufficient to fund the life insurance to a properly structured 419A multi-employer trust, and the trust acquires the life insurance policies. The policies are designed to accumulate large cash values early in the life of the policies.

When Dr. Smith (or the other physician/owners) retires or leaves the group, his policy is distributed to him by the multi-employer trust. The cash surrender value is large enough to allow Dr. Smith to take a tax-free distribution from the policy to pay income tax on the value of the policy, and to continue to receive tax-free cash surrender value distributions throughout his retirement years.

The tax-deferred inside build-up within the insurance policy has, in effect, self-funded Dr. Smith's income tax payment, which results from distribution of the policy to him, and has provided significant additional funds accessible to Dr. Smith on a tax-free basis either immediately or as needed during his retirement years.

Doing It Right

The example above illustrates just one of the advantages of a 419A plan, but there are many others. If you are considering a 419A plan, it is important to access qualified professionals who know how the plan should be structured (your CPA, attorney and insurance specialist), and to fund the plan through a multi-employer trust that has obtained a tax opinion regarding the intended tax benefits. Several of these trusts are available and already have hundreds of participating employers. ■

MaGee is the director of taxation in the central Arkansas practice of Baird, Kurtz & Dobson, CPAs. He is a technical consultant for The Advantage Plan, which is a 419A plan sponsored by AMS Benefits, Inc., a wholly owned subsidiary of the Arkansas Medical Society.

PEOPLE+EVENTS

HONORED

Dr. Tompkins Honored for Community Work

Dr. Carl Tompkins of Bella Vista recently received an Ageless Heroes Award in the community involvement category in Springdale.

In her nomination essay, Dr. Tompkins' wife, Linda, wrote, "His life goal is to leave his world better than he found it. I think he is doing that."

Dr. Tompkins maintains his physician's license, is a facilitator for three support groups and volunteered as a hospice medical director. He's also trying to bring another nursing home to Benton County.

The Ageless Heroes program, in its second year, is sponsored by Blue Cross and Blue Shield. About 260 Arkansans were nominated for the awards in 1999.

Dr. Tom Ross Award Given to Dr. Maupin

Dr. James L. Maupin of Dardanelle received the Dr. Tom T. Ross Award from the Arkansas Public Health Association at the organization's annual conference in Hot Springs.

Dr. Maupin, who practices family medicine

and general surgery, was a member of the Hospital Board of Governors for 22 years, was clinical director of the state tuberculosis sanitarium for five years and was medical director for the Arkansas Foundation for Medical Care. He also was a member of the state Board of Health for 16 years.

Three Appointed Liaison Physicians

Dr. Keith M. Heaton of Little Rock, Dr. Patrick Travis of Bentonville and Dr. Andre B. Whiteley of Springdale received three-year appointments as cancer liaison physicians for the American College of Surgeons' Commission on Cancer program.

Dr. Heaton will serve at University of Arkansas for Medical Sciences in Little Rock; Dr. Travis will serve at St. Mary's Hospital in Rogers, and Dr. Whiteley will serve at Northwest Medical Center in Springdale.

The Commission on Cancer, which began in 1922, reviews cancer programs for conformity to standards and encourages hospitals to provide patients with the latest services in the diagnosis and treatment of cancer.

New Members

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Specialty: Resident - Family Practice
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Raymond K. Coker, MD

Specialty: Resident - Family Practice
5715 South Country Club Blvd.
Little Rock 72207

OBITUARY

Louis Richard McFarland, MD, 77, Dies

Dr. McFarland, 77, of Hot Springs died May 30 in a Houston hospital.

Dr. McFarland, born in Arkadelphia in 1921, had a general practice in Hampton (Calhoun County), 1946-50, and was assistant resident physician at St. Louis Children's Hospital, 1951-52. He was in postgraduate training at Harvard Children's Medical Center in Boston in 1955 and was a staff member of St. Joseph's Hospital, Ouachita Memorial Hospital, National Park Medical Center and Leo N. Levi Hospital, all in Hot Springs.

He was a graduate of the University of Arkansas School of Medicine and was an intern at Baptist Hospital in Little Rock, 1944-45.

He is survived by his wife of 54 years, Lanelle Weldon McFarland, and three children — Robert Alan McFarland of Ventura, Calif., Dr. Michael Scott McFarland of Hot Springs and Pine Bluff and Jane Ann Cole of The Woodlands, Texas. ■

Flatiron Flats in Eureka Springs

Chances are you've seen photos of Eureka Springs' Flatiron Flats. Maybe you've walked past the building or admired it from the deck of the Basin Park Hotel.

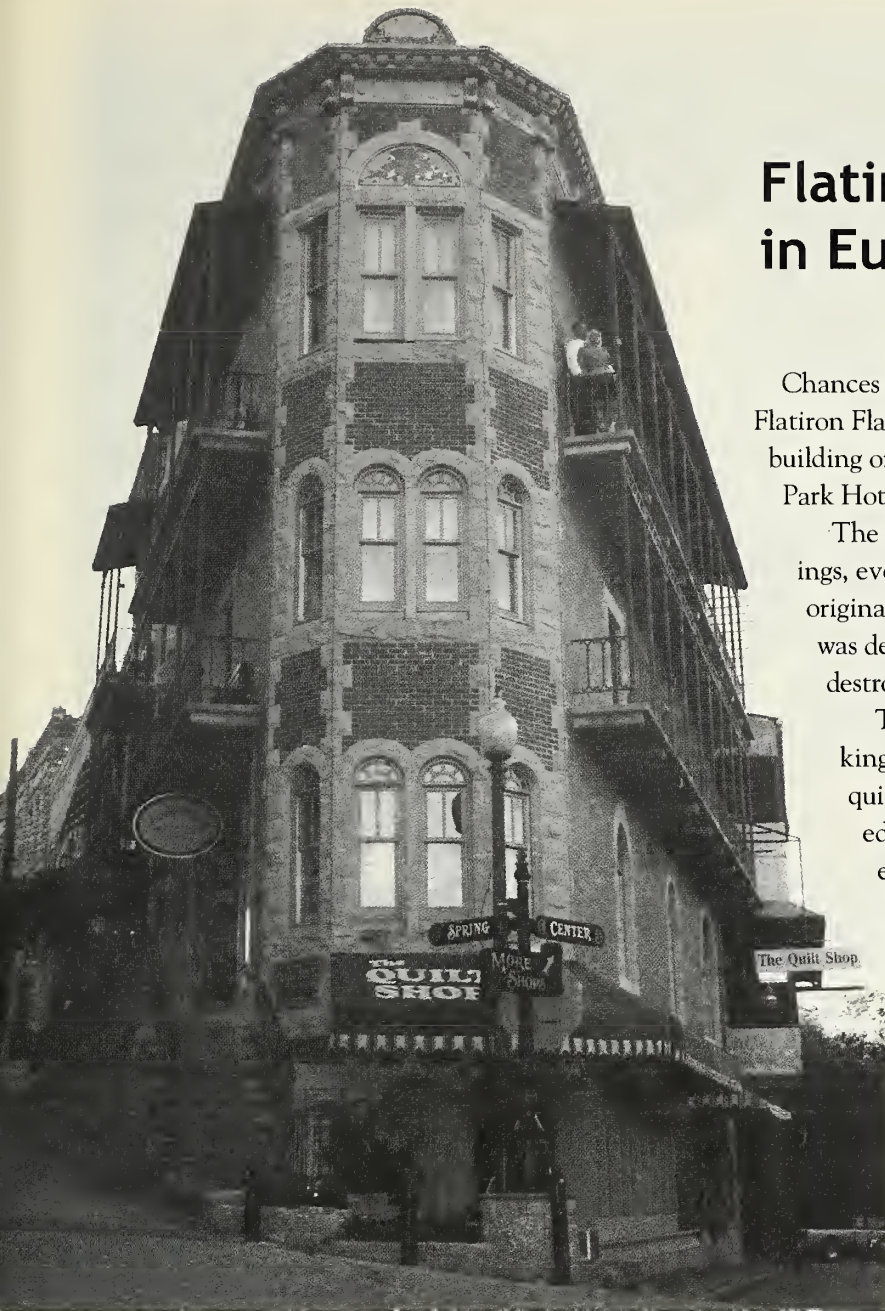
The building fits into its antique surroundings, even though it was built in 1987. The original Flatiron building was built in 1880 but was destroyed by fire in 1890. It was rebuilt but destroyed by another fire.

Today the building houses rooms with king-size beds, whirlpool bathtubs, Amish quilts and other comforts that can take the edge off a long day of shopping and exploring this unique village. Bath salts, chocolates, wine, cheese, fresh fruit, soft drinks, a refrigerator, a microwave oven, cable TV, stereo and access to a pool, hot tub and golf course are part of the deal, too.

But perhaps the best benefit is location. Flatiron Flats is smack dab in the middle of town, and parking is available on-site. That means you can park your car and not move it until your visit ends. Everything you need — fine dining, drinks, entertainment, shops — is within easy walking distance on Spring Street in the heart of Eureka Springs.

For more information write Flatiron Flats, 25 Spring St., Eureka Springs, AR 72632, call (501) 253-9434 or (800) 421-9615 or visit the web site at www.eureka-net.com/flatiron/. ■

The Flatiron Flats in Eureka Springs is hard to miss with its distinctive look. All the comforts of home are available in rooms that tout king-size beds and whirlpool bathtubs.



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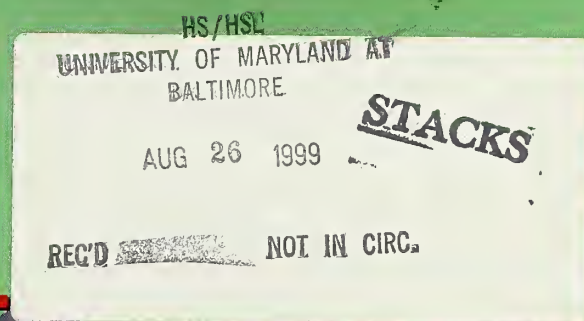
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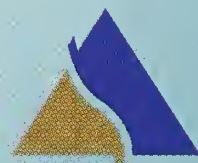
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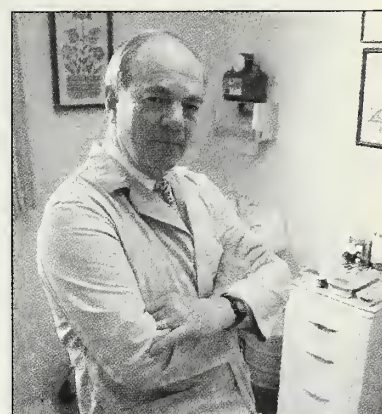
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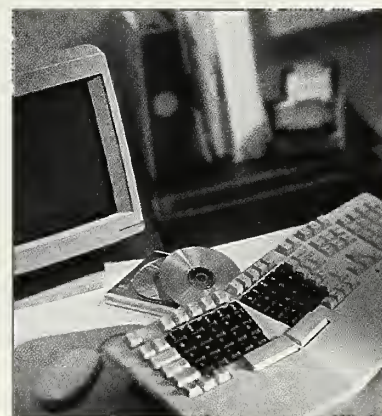
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COMMENTARY



The Academic Paradigm

ALEX E. FINKBEINER, MD

The College of Medicine Faculty Awards Banquet honoring excellence at the University of Arkansas for Medical Sciences College of Medicine was held March 18. This inaugural banquet included the presentation of the Master Teacher Award to George L. Ackerman, MD, professor of internal medicine. Following an eloquent and heart-felt introduction by Dr. Thomas Andreoli, Dr. Ackerman delivered the acceptance that follows: "Thank you Dr. Andreoli and Dean Wilson. No recognition could be more meaningful to me or more deeply appreciated than to be honored as a teacher.

We are molded and formed by multiple influences. If I have had any success as a teacher, it is reasonable to believe that my teachers played some role and deserve some credit. Let me recognize some who were important to me when I began to learn medicine, who taught me and in some instances are still teaching me.

- Ben Heller, who first interested me in renal disease
- Bill Ross
- Bob Abernathy
- Jim Doherty and Dr. James Taylor
- Kerry Juniper
- Jim Melby
- Jack Pierce

And, of course, Dick Ebert. Certainly the most fortunate event in my education was the privilege of learning medicine from Dr. Ebert. He was a master clinician and scholar whom I revered and admired above all others. No student could have had a better teacher, no apprentice a wiser master than Dr. Ebert.

I want to credit another group of teachers. Emerson said, 'I pay the school master to teach my son but he learns from his fellows.' Among the members of my residency group were:

- Joe Bates
- Lou Sanders
- Bill Chew
- Pat Henry
- Coy Fitch
- Van Smith
- George Mitchell
- Sexton Lewis and others.

They created a milieu where learning medicine seemed the most rewarding and exciting thing we did. From that group of just over 20 house officers, there came six professors of medicine.

I wish also to express my gratitude to our university and especially to the present leadership. The growth and the changed character of our institution

in the last 20 years would have been thought impossible when Harry Ward arrived here in 1979. Equally impressive have been the changes wrought by Dodd Wilson in the College of Medicine. All of us should feel a deep sense of gratitude for them.

I have had the good fortune to have been a member of the Department of Medicine where teaching has been a valued tradition, an attitude that, to the great credit of Tom Andreoli, remains true even in these difficult times when bedside teaching is threatened by economic pressures.

And finally, on a more personal note, my wife and daughters have been a constant source of pride and happiness. I am grateful to them beyond telling, for making me happy.

You have honored me by dubbing me a Master Teacher. I am not sure that that is correct, but I am happy to bask in this moment of glory. If it is true, I suppose it would be fitting for me to divulge the secrets of masterful teaching. However, I am not sure that the process bears too close an examination. My father told a story many years ago of the older man who had a long flowing beard and who was asked by his grandson, 'Granddaddy do you sleep with your beard under the cover or out of the cover?'

'I don't know,' he replied, 'but I will tell you in the morning.'

The next morning, though, he got up and shaved his beard because, of course, he was unable to sleep with his beard beneath or out of the bed clothes.

The Japanese Zen Master is said to have advised his students, 'Don't think of what you have to do, don't consider how to carry it out!'

The only secrets I know are very obvious ones. Put yourself in the student's place. Think if what you are saying or doing is being registered and if it is helpful to his learning. Never build your ego at the expense of the students. This is perhaps the cardinal

sin for any teacher.

I suppose I have license to give some additional unsolicited advice and I will.

First, for the basic scientist. Remind the student of the wonder of the human body and of the miracles of biology, of the intricate and miraculous system that keep us coping. It doesn't require any lessening of the importance of the scientific to note for the student the infinite number of arrangements, of the checks and balances and fail-safe mechanisms that have evolved over the ages to ensure as far as possible the organisms' survival. Surly it is more rewarding and pleasant to learn if we marvel at the subject we are studying.

For the clinical scientist. With the rapidly advancing technology of medicine, technology that has changed medicine with tremendous benefit for our patients, we must not lose the ability to talk to our patients, to know them, and to communicate our interest in them, and we must demonstrate this practice to our students. We must insist that the student consider the patient first and the CT scan, the MRI and the echocardiogram second.

The conflict between knowledge and wisdom, between science and humanism, is not a new one, for it is these two disparate values that are symbolized by the two intertwined snakes on the caduceus. The doctor who ignores science — or our students who do not learn to use it — denies his patients the benefits of the revolutionary advances of the last half of this century. The doctor, or student, who forgets the patient, the object of his science, never gains the wisdom of the physician and betrays

First, for the basic scientist. Remind the student of the wonder of the human body and of the miracles of biology, of the intricate and miraculous system that keep us coping.

the greatest traditions of our craft.

We must encourage and guide our students in blending knowledge and wisdom, science and humanism, an understanding of the powerful scientific and technical tools we have in our hands with the empathic and compassionate concern for the person they are caring for.

The two are the requisites of the good doctor, either of them alone makes either an uncaring technician or a warm, but not fully competent, counselor.

How fortunate we are to be able to practice the sciences and to have the opportunity to teach. We must recognize that this is a calling with great responsibility, but surely there are few with greater rewards.

In closing, I again express my gratitude for having had the opportunity to learn and to teach at our university and again state my profound thanks for this award."

In his speech, Dr. Ackerman expressed his gratitude for having had the opportunity to learn and to teach at our university. On behalf of all of us who have had the privilege and honor to have interacted with this master teacher — whether we were a medical student, resident, colleague, referring physician or a patient — we wish to express our gratitude to you for teaching us well by reaffirming and uplifting us medical neophytes in such a gentlemanly manner or to express it in the current idiom, "George, you da man!" ■

Dr. Finkbeiner is chairman of urology at UAMS and is a member of the editorial board for The Journal of the Arkansas Medical Society.

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FROM THE AMS STAFF

Medical Journey for Many Starts This Month

August at the Arkansas Medical Society means time for students — medical students to be exact.

About 150 young (and some not so young) students from all walks of life begin their first year of medical training at the University of Arkansas for Medical Sciences each August. They arrive on campus with healthy doses of nervousness and excitement.

Their first exposure to the Arkansas Medical Society and organized medicine comes during freshman orientation. For several years UAMS has given students the opportunity to complete membership applications for the AMS during the orientation process. Leaders in the AMS Medical Student Section (AMS-MSS) are available to the newcomers.

AMS support of student orientation is never more evident than at the White Coat Ceremony. This ceremony is the high point of orientation week. With parents watching proudly, each new student marches across the stage and pulls on the first official "white coat," assisted by a distinguished member of the faculty and the AMS president. Last year, AMS President Michael Moody, MD, of Salem began a tradition of handing each student a card-sized laminated copy of the AMA Code of Medical Ethics, which many students continue to carry with them.

While this may be the starting point for medical students, it is only the beginning of their involvement with the AMS. Students play an active role in our association's activities and now have a voting member on the AMS Council and AMS committees.

The AMS also sponsors three lunch programs each semester for students and provides funding for students to attend the annual and interim meeting of the AMA House of Delegates.

The most recent project of the AMS-MSS was the creation of a mentoring program to be offered for the first time to this year's incoming freshman class. The mentoring program will match a medical student to a practicing physician member of the AMS. The goal is to provide students with the opportunity to interact with physicians in private practice. Look on page 82 of *The Journal* for a form to volunteer as a mentor.

Student members of the AMS also participate in volunteer efforts to help others. Last year, for example, the students sponsored two book sales and a faculty-student volleyball game to benefit Arkansas Advocates for Battered Women.

Medical student members of the AMS enjoy the same membership benefits as physician members, except their dues are waived. They receive the same AMS newsletters, *The Journal*, plus reduced registration fees for Annual Session and other AMS functions. Students continue to be exempt from dues until their second year in practice. This means that for each student joining during the freshman year, the AMS contributes a minimum of \$3,500 in waived membership dues.

The AMS has made a conscious effort to reach out to medical students because they truly are the physician leaders of tomorrow. One day they will be running the AMS, and we hope they will remember their days as students and the fond memories of their first experiences in the AMS. ■

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beams of radiation intersecting to form a precise tool. These beams are focused on the target area destroying only that which is abnormal, while sparing adjacent, normal tissue from clinically significant radiation.

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Conventional neurosurgery typically means a lengthy hospital stay, expensive medication and sometimes months of rehabilitation. The Gamma Knife reduces these costs greatly. Patients are usually able to leave the hospital the same day and resume their normal activities immediately. Post-surgical disability and convalescent costs are typically minimal. At the same time, it provides patients with dramatically improved quality of life by avoiding post-operative complications such as hemorrhage and infection associated with conventional surgery.

PROVEN

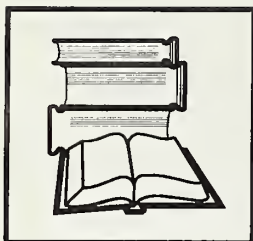
The success rate of the Gamma Knife is unprecedented. It has established clinical efficacy for many reported indications including obliteration rates in AVM's, and treatment success rates for acoustic neuromas, meningiomas and metastatic tumors. Close to 100,000 patients have had Gamma Knife radiosurgery with no mortality and minimal morbidity reported. Backed by over three decades of clinical experience and documented results. No other neurosurgical tool has met with such impressive results.

For more information on the UAMS Gamma Knife Center call Mark E. Linskey, M.D., Co-Director, Neurosurgery at 501/686-5270 or Dennis Shrieve, M.D., Ph.D, Co-Director, Radiation-Oncology at 501/686-7100.



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Arkansas Medical Society Medical Student Section Mentoring Program

The Arkansas Medical Society is pleased to announce the establishment of the Arkansas Medical Society Medical Student Section Mentoring Program.

Webster's Dictionary says a mentor is "an experienced and prudent advisor."

In the AMS-MSS Mentoring Program, a mentor will be someone who wants to take an active role in supporting the cause of medicine and the future of the medical profession. The goal of the mentoring program is for medical students to become interactive with practicing physicians from across the state. In order to accomplish this goal, medical students from the AMS-MSS will be matched with the mentor volunteers from the Arkansas Medical Society. **Why should you be a mentor? Consider the following reasons:**

- Mentoring is a natural role for physicians.

You have been the beneficiary of countless teachers and mentors as your career has progressed.

- Mentors have the opportunity to establish rapport with a new generation of physicians, learning their concerns and have a chance to enhance their professional experience.

The qualifications for the AMS-MSS Mentoring Program are as follows:

- Mentors must be in active private practice.
- Mentors must have completed at least three years of active private practice.
- Mentors must have a willingness to share their experience and time with students.

How will this work and what is required?

All that is required of a mentor is to make at least one quality, face-to-face contact a year with his or her assigned student. The mentor also must agree to have contact with the stu-

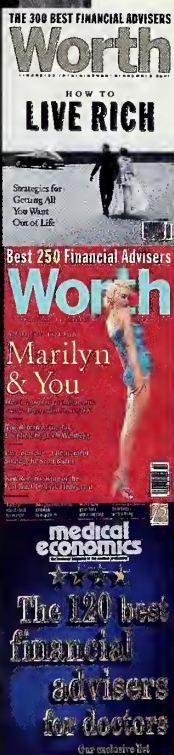
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dent on a monthly basis, whether it is by phone, letter, post-card or e-mail. Each mentor will have his or her own style — some will make repeated personal contacts, invite students to breakfast or lunch and so on. Others will write a letter, send an e-mail or interesting news article or invite the student to an AMS meeting.

How do you become involved?

Joining the AMS-MSS Mentoring Program is simple. Just complete and return the attached commitment card to the Society office at PO Box 55088, Little Rock, AR 72215 or fax it to 501-224-6489. You can e-mail your interest in the mentoring program to ams@arkmed.org.

----- **Commitment Card** -----

Arkansas Medical Society Medical Student Section Mentoring Program

Please print all information clearly.

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IN + THE + NEWS



Magazine Features Children's Hospital

The July 19 issue of *U.S. News and World Report* includes Arkansas Children's Hospital and Dr. Milton Waner in a feature called "America's Best Hospitals."

The work of Dr. Waner, director of the Vascular Anomalies Program and Center of Excellence at Children's, covers eight pages, including eight photographs.

Dr. Waner's 14-member vascular anomalies team works with disfiguring birthmarks, known as hemangiomas and vascular malformations, which can be very difficult to remove. The team includes otolaryngologists, plastic and reconstructive surgeons, dermatologists, interventional radiologists, pathologists, orthopedic surgeons, hematologists, orthodontists and nurses.

"It is the goal of our team to provide this medical treatment and help these children live normal lives," said Dr. Waner, who developed the only successful technique used to remove

the formations. "What we're doing is helping kids and adults look normal."

Foundation Handing Out Health Care

The Arkansas Health Care Access Foundation has provided free medical service to 15,726 medically indigent persons as of June 1999. This program has 1,956 volunteer health professionals including medical doctors, dentists, hospitals, home health agencies and pharmacists. These providers render care in 69 of Arkansas' 75 counties.

The organization was formed in 1989 by the Arkansas Medical Society to provide free medical care to low-income Arkansans who are uninsured. For more information call (800) 950-8233 or (501) 221-3033 in Little Rock.



FTC Targets HIV Home Kits From Internet

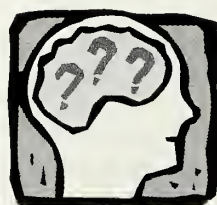
According to a consumer alert from the Federal Trade Commission, some human immunodeficiency

virus home test kits have given users false information.

The FTC tested kits for sale on the Internet and, in each case, the kits showed a negative result when used on a known HIV-positive sample. Some advertising with the kits imply they have been approved by the World Health Organization or that home-test kits have been approved by the U.S. Food and Drug Administration.

WHO and the FDA do not approve the kits. The FDA approves one home collection system — the Home Access Express HIV-1 Test System — that allows a test subject to collect a sample that is sent to a laboratory for testing.

The alert — along with others — is posted at www.ftc.gov. Call (202) FTC-HELP for more information.



Alzheimer's Database Available

A clinical trials database of compounds to treat Alzheimer's disease has been set up by the Na-

tional Institute on Aging with assistance from the U.S. Food and Drug Administration.

The internet web site is www.alzheimers.org. Click the "Clinical Trials" link.



Study Finds Pap Test Still Best

According to a report from Duke University in Durham, N.C., the conventional Pap test remains the most cost-effective means for detecting cervical cancer in adult women.

The school's analysis included three new technologies — ThinPrep, AutoPap and Papnet. The American College of Obstetrics and Gynecology, which recommended that the new methods be compared, was a partner with the school during the tests.

The report — "Evidence Report on the Evaluation of Cervical Cytology" — is on the National Library of Medicine's HSTAT database, which can be reached through "Clinical Information" at www.ahcpr.gov. Printed copies are available by calling (800) 358-9295. ■

100 YEARS AGO

Prominent AMS Member Dies

Dr. Clifton S. Gray was born near Sedalia, Mo., January 2, 1851, and died of pneumonia after about one month's illness at his home in Little Rock, Ark., February 14, 1899.

His education, both literary and medical, was principally acquired in his native state. He came to Fayetteville, Ark., about 1873, where he succeeded in establishing a splendid practice. In 1875, he was a delegate to the convention held in Little Rock, out of which was organized the Arkansas Medical Society, and was one of its most prominent members up to the time of his death.

He married, in 1886, Miss Fannie Ashley, granddaughter of Senator Chester Ashley, who represented Arkansas in the U.S. Senate from 1844 to 1848, and daughter of Wm. Ashley and Mrs. Fannie Ashley, who died last year at an advanced age. His wife and a nephew, Clarence Gray, of his immediate family, survive him.

The beautiful tribute from the *Arkansas Democrat* of February 15th is herewith submitted:

"Dr. Clifton S. Gray was one of Little Rock's most popular and widely known practitioners, his speciality being the eye and ear. As an oculist and aurist, his reputation was statewide, and he enjoyed a most extensive and lucrative practice.

Dr. Gray was ambitious, jealous of his profession, and devoted to his work, even to the detriment of his own health." ■



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Collective Bargaining is AMA's Answer to Managed Care Woes

BY NATALIE GARDNER

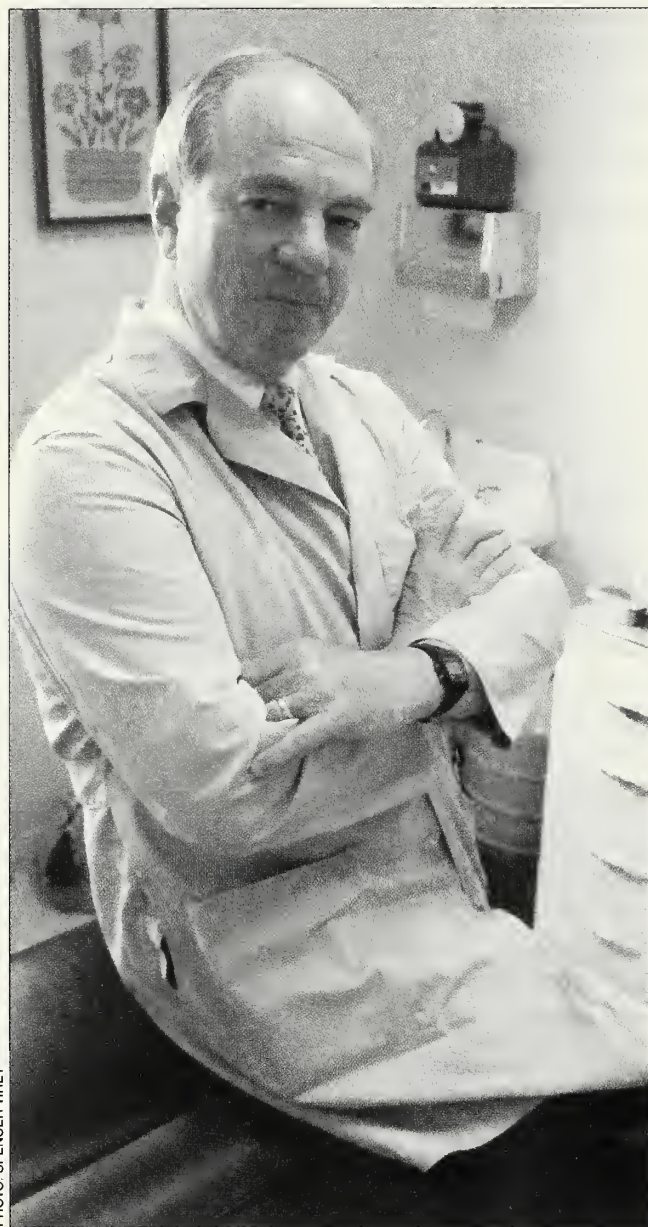


PHOTO: SPENCER TIREY

Dr. Bill Jones would rather the AMA take a wait-and-see approach to patient rights legislation.

The American Medical Association's vote last month to form a collective bargaining unit to battle managed care is a strong move, but will affect only a small percentage of the country's doctors unless Congress votes to reform federal antitrust law to allow self-employed physicians to form collective bargaining units.

The AMA's decision to create a negotiating unit for physicians is a symbolic statement against managed care by the 152-year-old conservative professional group. But as it stands now, these collective bargaining units can represent only the 108,000 post-resident physicians who are salaried employees, as well as residents. Salaried doctors and residents represent about one-third of the nation's 620,000 practicing physicians.

Arkansas delegates to the AMA's 494-member House of Delegates include Dr. Bill Jones, a dermatologist in Little Rock; Dr. John Burge, a general surgeon in Lake Village; and Dr. Larry Lawson, a general surgeon in Paragould. All three delegates voted against the formation of AMA collective bargaining units.

On the day before the AMA's June 23 vote to form the units, a House Judiciary Committee held a hearing to debate the Quality Health Care Coalition Act of 1999, also known as the Campbell Bill, an act to allow self-employed physicians to join together to negotiate with health plans. Current law does not allow self-employed physicians to discuss fees with other doctors.

The resolution would allow private-practice physicians to engage in joint negotiations with health plans but would not allow strikes and would not require physicians to negotiate through a labor union. AMA leaders said its collective bargaining units will not be traditional labor unions and will never strike, compromising patient care.

"This is not for all physicians," said Dr. Randolph D. Smoak Jr., chairman of the American Medical Association, in a released statement. "This will not be a traditional labor union. Your doctors will not strike or endanger patient care. We will follow the principles of medical ethics every step of the way."

"This will not be a traditional labor union. Your doctors will not strike or endanger patient care. We will follow the principles of medical ethics every step of the way."

— Dr. Randolph D. Smoak Jr., AMA

Battles with Managed Care

Doctors with the AMA said the need for collective bargaining is due to patient care being neglected by managed care entities for the sake of profits. The constant battles between health plans and physicians about the treatment of patients has gone on too long, they said.

"I deal with managed care organizations on a daily basis," said Dr. Burge, an Arkansas delegate to the AMA. "They are making medical decisions without any background to do that. We had no bargaining power with managed care; we needed the ability to negotiate with these companies."

Dr. Burge voted against the formation of the negotiating units because he felt the vote would have a negative affect on the Campbell Bill's chances in Congress.

"It's not that I don't feel we need collective bargaining units," he said. "But at the same time the Campbell Bill was in committee and I could foresee our vote affecting the bill's chances. I also don't relish the idea of being called a union."

Professional Image

Dr. Bill Jones, another Arkansas delegate to the AMA, said he voted against collective bargaining units because of what it might do to the professional group's image.

"The whole thing demeans the medical profession," he said. "We are not a trade organization; we're a professional group. Is it worth the loss of public esteem of the medical profession when it can only affect a small percentage of physicians in the country?"

Many physicians, including Dr. Jones, feel the AMA should wait and see what happens with the patient rights legislation currently being debated in Congress to solve many of the problems they have with managed care.

"I would have rather seen us do nothing, and let this play out," Dr. Jones said. "Patients are on our side, and they're going to push this thing to more reasonable care for patients.

We need to concentrate on changing some of the law."

Officials with Arkansas' health plans disagree that the AMA's collective bargaining units will help increase patient quality. They say the units just mean higher premiums for patients.

"If reimbursement to doctors goes up, there will be an increase to the premium dollar," said Rob Herndon, CEO of United Healthcare. "If they form a union and don't force an increase in cost, then the cost of insurance won't increase."

Health plan officials contend a physician union would have little to do with health coverage; that falls under employer's decisions.

"Employers buy the benefit packages," Herndon said. "We negotiate with the employers, not the doctors on coverage."

Arkansas Blue Cross and Blue Shield officials said they are confident their current medical policy meets physician standards, and they foresee no problems with the AMA's decision.

"Our medical policy is developed after consultations by medical management groups comprised of practicing physicians," said Max Heuer, spokeswoman for Blue Cross and Blue Shield. "We align ourselves with those who are practicing quality medicine. With consultation and cooperation, the most efficient medical treatment can be established."

The AMA's surprising decision to form physician unions is not just a cry against managed care, members said, but a response to many younger physicians' problems with the state of medicine.

Over the past years, the AMA has declined in membership, struggling to gain new younger members. Many of these younger physicians are on salary, a stark contrast to many of the AMA's older self-employed members.

"These younger physicians and residents have to have a need to belong to the AMA," Dr. Jones said. "If the AMA can't offer them a collective bargaining unit and come down to the hospitals to help, they won't see any relevancy in AMA benefits."

And residents face a whole new set of problems that the AMA is realizing must be addressed. Although residents expect low pay, many are overworked and aren't getting the supervision they need to practice safe medicine, said Sandra Marchese Johnson, a dermatology resident at the University of Arkansas for Medical Sciences.

Johnson attended the two previous AMA meetings before last June's meeting and listened to residents' concerns.

"They are overworked, they don't have health care benefits, and some don't have the support they need from attending physicians," she said. "They are having to act as a physician, but they don't have the experience."

This is where collective bargaining units can help these residents, Johnson said. At UAMS, dermatology residents don't have these problems, but residents in surgery and internal medicine are struggling with many of these situations.

"I'm not dealing with these problems myself, but I see them all around me," she said. "Many residents are unhappy, and it's nice to know there's someone on your side. When you're working 30 hours straight, you can't give good patient care."

Antitrust Relief

Although residents will be assisted through the AMA's negotiating units, possibly by next month, self-employed physician members will spend their time lobbying Congress for antitrust relief.

At the June 22 House Judiciary Committee hearing, officials with the Justice Department and the Federal Trade Commission testified against granting an antitrust exemption to self-employed doctors. They said allowing self-employed physicians to band together to negotiate with health plans would result in substantially increased fees for doctors, higher insurance premiums for consumers and an increased number of uninsured Americans.

"The Commission continues to believe that such an exemption would be bad medicine for consumers," tes-

tified Robert Pitofsky, chairman of the Federal Trade Commission. "The bill's stated purpose is to promote the quality of patient care. Collective bargaining by health care professionals, however, does not ensure better care for patients."

The Commission believes competition among health plans and health care providers is an important tool in controlling costs, but AMA officials say that is at the cost of patient care.

Doctors argue that managed care organizations are making medical decisions without physician consent and overloading them with so much paperwork that there is no time to spend with patients.

"Allowing physicians to be an effective counterbalance to health plans in negotiations over contractual terms that directly affect patient care will better serve the health care needs of the American public," testified Dr. E. Ratcliffe Anderson Jr., executive vice presi-

dent and CEO of the AMA, at the hearing.

History Repeats Itself

Although many found the AMA's decision to form negotiating units as surprising, it's not unheard of for professional groups to use collective bargaining strategies, said Grainger Ledbetter, a labor education specialist with the University of Arkansas at Little Rock's labor education program.

"A good example is the teacher's union. It was unheard of for teachers to collectively bargain up until the '60s," he said. "The National Education Association has an ongoing debate about whether they are professionals or a union. But the circumstances dictated that the NEA take a serious look at collective bargaining. So this is not an unusual debate about whether professionals should pursue collective bargaining."

Some in the labor relations industry raised questions about whether the

AMA could have any leverage with health plans without the ability to strike, but Ledbetter says many unions don't strike.

"Federal employees, nurses, firefighters, all don't strike," he said. "They have mandatory mediation or arbitration, where the disagreement is settled and it's binding."

Yet with all the questions and uncertainty surrounding the AMA's decision to form collective bargaining units, doctors want patients to understand that this is the next step in fighting for quality patient care. They contend this is the only way to get health plans to include doctors again in medical decision making.

"Ten to 15 years ago if you would have told me we were going to do this, I'd say you were crazy," Dr. Burge said. "But we've been backed into a corner, and this is the only answer. We've got to be able to have some ability to negotiate with these managed care organizations." ■

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Meet Our Members

Fay Boozman, MD

By JUDITH M. GALLMAN



PHOTOS: RUSTY HUBBARD

Solving State's Health Problems Is Possible

New Director Pushes for Creative Solutions

Arkansas is a diverse state with varying health problems, but among its most critical are teen pregnancy, teen smoking and infant mortality and morbidity.

That's the opinion of Dr. Fay Boozman, the new director of the Arkansas Department of Health. Dr. Boozman, 52, of Rogers, took over the department in February.

"It's not so important what we think; it's what they think," Dr. Boozman said about Arkansans. "Every place is different."

In a July interview in his neat fifth-floor office at the health department, Dr. Boozman discussed his views and goals

as director toward the end of his first six months on the job. Health needs of Arkansans vary depending on the geography and socioeconomic climate of the state, Dr. Boozman said. In rural and poor areas, for instance, the health department unit may be a county's sole health resource. Such a community may be without clean water or adequate sewer systems, or women may have to travel long distances to reach the nearest services for delivering babies.

Health units in larger counties, where "there may be three or four major hospitals with a physician on every corner," have a different role, Dr.

Boozman said. Their efforts might be focused on other issues—identifying venereal diseases or AIDS cases and providing immunizations and drug and alcohol treatment programs.

Dr. Boozman plans to set up "health coalitions" in each of the state's 75 counties to best determine each area's specific needs and resources. Such coalitions will bring together politicians and officials from schools, county and city governments, churches, businesses, service agencies, higher education and elsewhere in round-table discussions to determine each county's compatible resources, overlaps and unmet health needs. The talks, Dr.

Boozman believes, will lead to creative solutions and a coordinated, streamlined public health delivery system.

"We must inventory what we've got," Dr. Boozman said, predicting resources and overlaps will be greater than anticipated.

A pilot program is already under way in Boone County. The program, the Hometown Health Improvement Project, has brought 40 to 50 community leaders together to discuss the area's health needs and health services, and the volunteers are assessing those needs. Dr. Boozman said he is "very pleased" with the cooperative spirit of the program, which uses existing funding sources.

Other goals Dr. Boozman has for the department, which employs 3,000 workers, includes modernizing computer capabilities and technology as well as developing career pathways within the department for its professional employees, including a new scholarship program for employees to pursue environ-

mental health studies.

Strong, too, on his mind is the fact that children in elementary school are more overweight than ever before, which bodes ill for their futures. In 20 years, these overweight children could very well be obese adults with diabetes, and in 10 more years they may suffer heart attacks, he said. Plans to deal with this growing problem include encouraging exercise among these children with newly built hiking trails and more sidewalks. He also believes physical education should be emphasized more in schools.

Mixing Medicine and Politics

An ophthalmologist with pediatrics training, Dr. Boozman, a Fort Smith native, attended the University of Arkansas for Medical Sciences. He ran a private ophthalmology clinic in Rogers for four years then entered a group practice, Boozman-Hof Eye Clinic, for seven years, giving him a solid background in administration. He recently returned to

the classroom to pursue his master's degree in public health through Tulane University curriculum offered at UAMS and plans to emphasize environmental health.

Dr. Boozman also has a background in politics and is a former one-term state senator. He also was the Republican nominee for U.S. Senate, but lost the race to Blanche Lincoln.

The expertise as a state senator, he said, gave him an advantage at the 1999 legislative session in that he understood in advance how the system worked and could act as a better advocate for the department. Dr. Boozman is particularly proud of new legislation creating a new nurse home visitation program for pregnant teens and unwed mothers. The program allows a nurse to help a young mother understand her prenatal, perinatal and postnatal health needs, emphasizing preventing repeated pregnancy, working toward educational achievement, entering the work force and ensuring children's health.



Clockwise (L-R): Bill Smith, Keith McCullough, Stan Russ, Stephen Chaffin and Jim Strawn.

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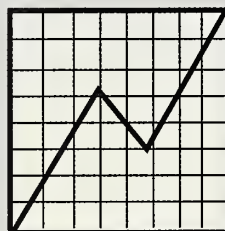
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What studies show, Dr. Boozman said, is that such education can reduce the chances of the young mother getting pregnant again. Additionally, the education can help women get off welfare and into the work force, and the chances of success improve for their children.

"You're breaking the cycle," Dr. Boozman said. His hope is to have the program up in four "pods" across the state that would employ four nurses who each would assist 25 young women. The pods likely will be in the state's four congressional districts.

A Grassroots Initiative

Dr. Boozman said he sees his role as health department director as one of facilitator whose duty is to enable health professionals to get their jobs done.

"I don't micromanage," he said, adding he has no major changes planned for the department. "I carry out the public health policy that's given to us by the Legislature and the governor. ...

We're not a policy-making [entity]; we're a carrying-out [entity]."

Dr. Boozman replaced Dr. Sandra Nichols, who had begun a strategic planning process for the health department known as ASPIRE. Dr. Boozman has continued the internal evaluation project, which he described as a "grassroots" employee-support initiative. Dr. Boozman's prioritization of the department's programs, he said, has coincided with some ASPIRE findings and recommendations.

Road to the Department

Dr. Boozman's appointment as health department director was controversial. In initial interviews, he was overlooked in favor of two other candidates, but Gov. Mike Huckabee, a Boozman supporter, insisted that a third candidate be added to the list of applicants, and Dr. Boozman's name was submitted. That's who Huckabee chose, calling Dr. Boozman "one of the most genuinely decent people who has

ever been in public service."

While campaigning for the U.S. Senate, Dr. Boozman, a Baptist and outspoken foe of abortion and abstinence proponent, angered some when he said that women rarely get pregnant during rape because their bodies produce a hormonal shield as a result of stress that precludes pregnancy. He apologized for the statement but stood by his beliefs. As a state senator, he worked hard for a bill banning partial-birth abortions.

Dr. Boozman said there is no conflict in his personal views and public health policy.

"When asked, the thing that I want is [that] every policy is based on scientific data," he said. "We are scientists. We help guide lawmakers."

"My total commitment is to the health department and what we're doing," Dr. Boozman said when asked whether he wants to return to politics. "I had to work through that before I was considered for this position." ■

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UAMS Unit Charts Course to Paperless Office

By NATALIE GARDNER

Only about 5% of the country's medical community works within paperless offices, but a group practice in Little Rock has made the transition and is reaping the benefits.

There are no medical files for new patients, prescription pads or an army of medical transcriptionists at the department of family and community medicine at the University of Arkansas for Medical Sciences. The department began building a true electronic medical records system in 1996 with Logician software.

A major reason for the switch was the lack of availability of charts. Charts were missing in action, either left on someone's desk or piled under paper.

"Before we only had 65 percent of the charts available," said Cynthia Weber, associate director for clinical services at the department. "Now 100 percent of the charts are available."

The system keeps track of a structured list of medications, diagnoses and allergies. It tracks and manages numeric data from the lab and addresses compliance issues.

As the physicians use exam room computers to prescribe drugs, the patient's medication list is updated. Once in the computer, a paper copy prints out down the hall and is signed by the physician before the patient leaves.

"Documenting the prescriptions after the fact is hard to remember," said Dr. David Nelson, a family practice physician with the department and a proponent of the EMR system. "The prescription went out the door with the patient, and the physician couldn't remember correctly to write his notes."

Even phone messages are done electronically and, with a click of the mouse, become part of a patient's record.

"There wasn't accurate or complete information going into patients' charts," Dr. Nelson said. "An EMR system forces you to take a hard look at what you are doing and the workflow. You have to examine in detail the activities in your clinic. It has saved us a lot of trouble."

Most physician offices, about 85 percent, tout computerized billing, but they haven't taken the next step toward EMRs.

The department's EMR system also has saved the department money. Many of the jobs at the clinic have changed, and Weber expects several of those to be eliminated in a couple of years.

The clinic had a staff member who pulled, filed and restocked files. Now that person manages records electronically, scanning necessary documents, such as referral letters and lab reports, to put in the EMR.

Transcription has changed dramatically. Many of the physicians, especially the younger ones, are entering their notes into the computer system. And as the department

adds voice-recognition programs, the need for transcriptionists will greatly decline, Weber said.

The cost of medical files has decreased from \$1.99 for large files to 69 cents for thin files that hold documents that can't be scanned into the EMR.

Patient confidentiality also is better with the EMR system, Weber said.

"With a medical record, it was easy for anyone, a custodian, whoever, to pull a chart, sit down and read it," she said. "Now only certain people have access to charts and they must use a password to get to them."

Other immediate benefits include the ability for doctors to log on to Logician from home when taking a patient's call. This allows the physician to make a much more informed decision because the patient's complete record can be immediately pulled up on a monitor.

A New Workflow

A patient in the UAMS clinic is taken by a nurse to an exam room, where the patient's chart is opened on the computer. A summary sheet, which highlights the patient's key information, is printed out the night before for the physician.

The summary sheets first were used to serve as a backup in case the computer system went down, but the clinic's physicians liked to

have a piece of paper for note-taking with them in the room.

"Having those sheets is really nice," said Dr. Jamie Howard, medical director at the clinic. "You can update the problem list quickly without going to the computer. Many of us didn't like the fact that our backs were to the patient and we were facing the computer. We can use that summary sheet to spend time with the patient and take notes, so the patient doesn't feel like they are being replaced by a computer screen."

While many of the physicians tend to write notes and later type them into the computer, the system is set up with customized templates that allow someone to simply point, click and pull down items.

These structured data fields are easy to use when the procedures are routine, but if a patient's visit is complicated, notes are more useful.



"If I'm trying to understand the intimate details of a complicated history, I'm not typing into a computer; it's distracting for me and the patient," Dr. Nelson said. "Later, when I'm entering the information, if the history was complicated, a drop down, point and click form doesn't work; you need the freedom of prose, which the computer allows."

Once notes are typed in or dictation is completed, a physician must open a patient's record and sign off on the chart electronically. Once this is done, the notes can't be changed.

With the Logician system, physicians also can click on a button and determine the interaction between certain drugs. Before the EMR system, the doctors would have to look up this information in a book down the hall.

The system also tracks habits, diet, family history and social history and keeps a running tab of risks for certain diseases and illnesses.

And a major benefit to physician offices is the ability of the software to help with Health Care Financing Administration coding. The computer will let physicians know if their documentation is coded at the right level and will detail what needs to be included to move to the next level.

"If you use the system correctly, the level of visit you bill for is all documented," Weber said. "On level four and five new patients, this is really helpful. Some physicians feel uncomfortable about how they are coding, and this system really cuts down on mistakes and helps make physicians feel safe about an audit."

To Switch or Not to Switch

Dr. Nelson warns that each individual clinic has to examine whether switching to an EMR system is best. For the UAMS clinic, it was a natural transition since the clinic had a network of computers with e-mail capabilities for

doctors in the 1980s. In 1994, the clinic piloted a software program called SOAPware, which helped doctors prepare SOAP notes electronically.

"You have to look at whether it's going to cost you time, which is money," Dr. Nelson said. "If you are starting from a point of not knowing what a mouse is, yes, it's going to take more time and not be worth it."

For the private practice that is not computer savvy, the first step is putting a computer with e-mail and Internet capabilities on each desk. Let each person get comfortable with it on his own time, Dr. Nelson said.

"We had to set initial guidelines — if they wanted to dictate notes, type their own or use the structural clinical lists, we would support that, but not handwritten stuff," Dr. Howard said. "We told physicians we expected them to update the problem and medicine lists each time they saw a patient." ■

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RADIOLOGY



EDITOR: STEVEN R. NOKES, MD

AUTHORS: STEVEN R. NOKES, MD — DAVID BEVANS, III, MD — ROSE SHAW BULLOCK, MD — JOSUE MONTANEZ, MD

History

This 83-year-old male presented with a two-day history of nausea and vomiting. His initial acute abdomen series was suggestive of an ileus. His white blood count was 22,000. On day two he developed a low-grade fever (99.9°) and his white count increased to 33,000. A repeat supine and left lateral decubitus abdomen were performed (Figures 1 and 2).

Diagnosis

Emphysematous cholecystitis

Findings

The plain films reveal an air fluid level in the gallbladder as well as air in the gallbladder wall, best demonstrated on the lateral decubitus view. The luminal gas has a characteristic pear shape on the supine view. A limited CT scan (Figure 3) was obtained and confirms these findings.

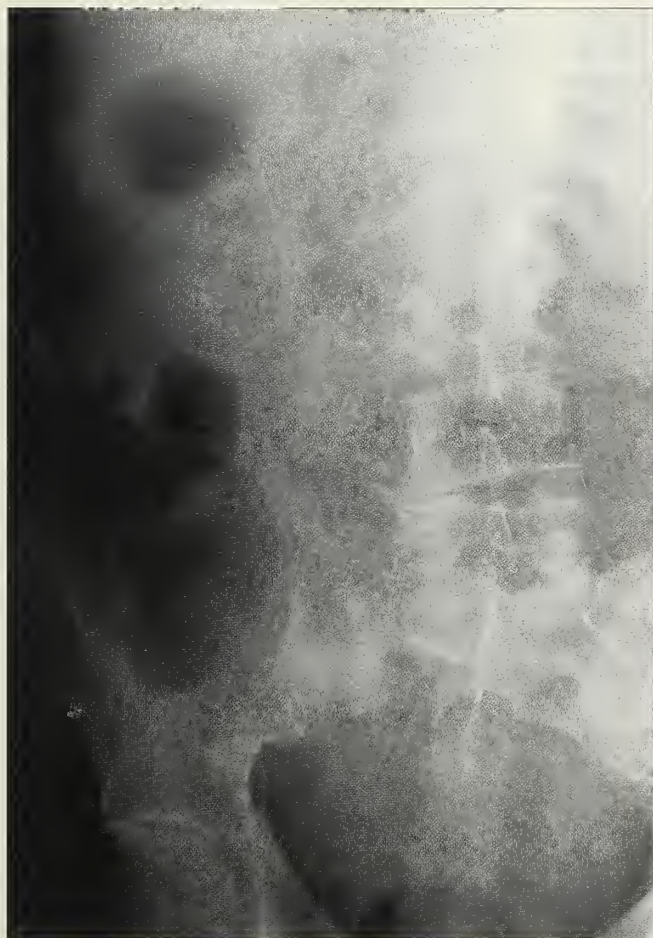


Figure 1. Supine abdomen



Figure 2. Left lateral decubitus abdomen

Discussion

Emphysematous cholecystitis is a complication of acute cholecystitis characterized by air in the wall or lumen of the gallbladder. In 20% of cases air is present in the biliary tree. There is usually obstruction of the cystic duct followed by ischemia and bacterial overgrowth of clostridium. This complication is much more common in men (5:1) and diabetics (30%). Gallstones are absent in 50% of cases. Patients often present with mild clinical symptoms in this disease, but the risk of gallbladder perforation is five times as great as other types of acute cholecystitis.

Gas in a duodenal diverticulum, an obstructed duodenal bulb and right upper quadrant abscesses can simulate gas in the gallbladder. CT is definitive. ■

References

1. Burrell MI, Zeman RK, Simeone JE, et al. The biliary tract: imaging for the 1990s. *AJR* 1991; 157:223.
2. Kahng KU, Rosalyn JT. Surgical issues for the elderly patient with hepatobiliary disease. *Surg Clin North Am* 1994; 74:345-373.
3. McMillan K. Computed tomography of emphysematous cholecystitis. *J. Comput Assist Tomogr.* 1985; 9:330-332.

Dr. Nokes and Dr. Montanez are with Radiology Consultants in Little Rock. Dr. Bevans is with Pulaski Surgery in North Little Rock. Dr. Bullock is with North Little Rock Primary Care and Diagnostic Clinic.



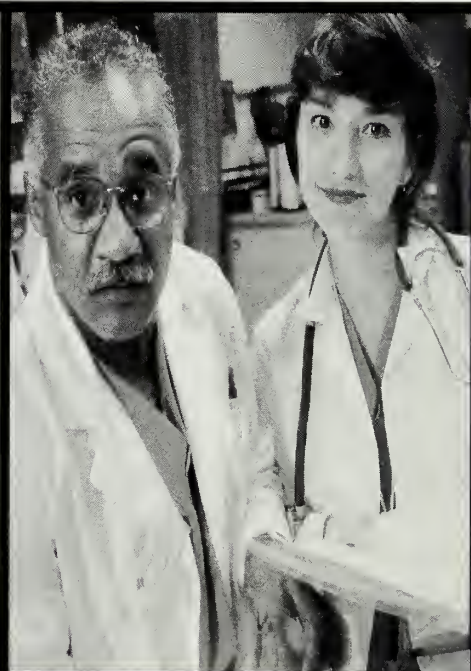
Figure 3: Noncontrast CT through the gallbladder fossa

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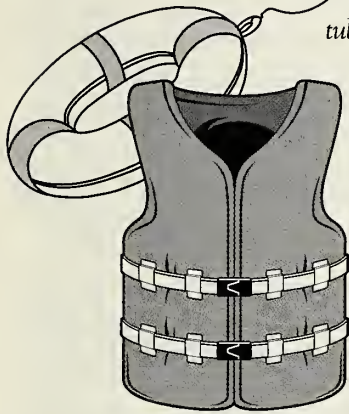
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Drowning Among Personal Watercraft Passengers: The Ability of Personal Flotation Devices to Preserve Life on Arkansas Waterways, 1994-1997

CHESTER S. JONES, PH.D



Personal flotation devices (PFD) are promoted and in many states are required for safe boating practices and to prevent drowning. Primary use of PFDs is associated with water sports (water skiing, tubing, etc.), boating and other water activities. Their purpose is to preserve life and prevent drowning.

However, their effectiveness to prevent drowning and near-drowning has not been well established. The purpose of this investigation was to determine the effectiveness of PFDs to prevent drowning and near-drowning of individuals involved in personal watercraft (PWC) crashes. Methods include the 48-month collection of PWC crash data from the Arkansas Game and Fish Commission for 1994-1997. Information on PFD use, swimming experience, whether passengers were ejected from the watercraft and crash cause was queried. Results show that 38% were not swimmers, 98% wore a PFD and 54% were ejected from the PWC. Alcohol was a causal factor in six crashes and one death.

It is estimated that PFDs saved 38 Arkansans who could have drowned. This study highlights one example of the effectiveness of PFDs to prevent mortality and morbidity.

Introduction

Boating is the most popular sports activity in the United States, with almost 25 million participants.¹ However, there are many risks for injury and death. In 1996, there were 709 boating-related fatalities.² More than 70% of the fatalities were caused by drowning. Yet, many of these may have been prevented if PFDs were worn. In boat-related drownings, 88% did not wear a PFD. Currently, 46 states mandate or have policies regarding the use of PFDs under certain conditions.³ Studies have investigated the reliability of PFDs to keep people afloat.⁴⁻⁶

However, information on the effectiveness of PFDs to prevent drowning and near-drowning is limited. This is due to (1) the rare incidence of drowning, (2) the low usage of PFDs and (3) ethics and difficulties of conducting studies where the outcome is either death or no injury. Alternatively, to consider the effectiveness of PFDs to prevent drowning, the absence or presence of other risk factors should be considered. These are: (1) ejection from the PWC, (2) swimming abil-

TABLE 1. Demographics of PWC crash victims by seat position (operator/rider), Arkansas 1994-1997

	Operators (n=186)		Rider (n=60)	
Characteristic	No.	(%)	No.	(%)
Age*				
1-12	15	(8)	14	(25)
13-18	61	(34)	28	(50)
19-33	66	(37)	11	(20)
34-55	35	(19)	2	(4)
56 and up	3	(2)	1	(2)
Gender*				
Male	139	(76)	19	(33)
Female	45	(25)	38	(67)
Swimmer (29 missing)				
Yes	96	(60)	37	(69)
No	65	(40)	17	(31)
Ejected				
Yes	96	(53)	33	(58)
No	87	(47)	24	(42)
Wore a PFD (2 missing)				
Yes	181	(98)	56	(98)
No	4	(2)	1	(2)
Injured				
Yes	72	(39)	30	(53)
No	114	(61)	27	(47)
*p<.05				

ity, (3) alcohol involvement, (4) boating education and safety, (5) risk-seeking behavior and (6) adult supervision.⁷⁻⁹ When looking at a combination of the risks, the

probability of drowning likely will increase. Therefore, research is required to establish how effective PFDs are at preserving life and preventing drowning and near-drowning.

No national estimates are available on the percentage of boat passengers who use PFDs. However, use among passengers on PWC (i.e. Jet Skis) can be very high. This may be attributed to the inherent risk of being ejected, the stability of the watercraft or state policies regarding PFD usage. Currently 50 states require the use of PFDs for all PWC operators and passengers.³ Studies have not indicated drowning as a major cause of fatalities in PWC-related injury.¹⁰⁻¹⁵ This is in contrast with other boat types that have drowning rates from 70% to 100%. Since PWC passengers have a high rate of PFD usage and a high risk for submersion, this may provide documentation on the ability of PFDs to prevent drowning and near-drowning. This study uses data from PWC crashes to make estimates on the ability of PFDs to preserve life and prevent drowning and near-drowning. The purpose of this study was to identify

risks for drowning and provide estimates on the number of Arkansans potentially saved from drowning among PWC passengers involved in crashes.

Methods

To describe the use of PFDs and injuries associated with PWC crashes, boating crash reports provided by the Arkansas State Game and Fish Commission from 1994-1997 were collected and analyzed. By state law, all boating crashes involving a fatality or \$100 or more in personal property damage must be reported to the Arkansas State Game and Fish Commission. The crash reports are collected by boating accident investigators certified through the U.S. Coast Guard. Most data is collected through personal interviews with the crash victims.

The measures obtained through personal interviews were: the victims' swimming ability, ejection from the personal watercraft, PFD usage, and boating education and safety training. The use of alcohol and the type of risky behavior were recorded by the interviewer during the crash investigation. Adult supervision was defined in this study as a person over the age of 21 who was in control of a PWC during the time of the crash.

Results

There were 108 reports of PWC-related crashes or incidents involving fatalities from May 1994-October 1997 on Arkansas waterways. Of these, 76 were boat-to-boat collisions and 10 were boat-to-object crashes. More than half of all reports (56%) were collisions between two PWCs. A total of 245 passengers were involved in the incidents. Demographics and victim characteristics by seat position are shown in Table 1.

Considering risk factors for drowning, most passengers wore a PFD (98%), were swimmers (62%), had no boating education (95%), no adult supervision (94%), no alcohol involvement (97%) and all but two crashes were caused by risky behaviors with PWC.

For victims who were submerged into the water by being ejected — those most at risk — 97% were wearing PFDs, 30% were nonswimmers, 93% had no boating education, 52% were 18 years of age or

younger and 58% had reported an injury. There were three cases that were attributed to alcohol. Of the six risk factors, there were 38 who had only the protective factor of PFD use.

There were five PWC-related deaths for the study years. Four of those involved passengers. One death was identified as a diver who was fatally struck in the head by a PWC. Among the other four fatalities, there were two drownings and two fatalities from head trauma following impact from another boat. Of those who drowned, both were swimmers and did not wear PFDs. Alcohol was a contributing factor in one of the drownings. The other drowning did not involve a PWC crash. The victim was swimming intentionally after stopping the PWC in the middle of a lake. There was one 14-year-old male survivor of a crash who did not wear a PFD, was a non swimmer and was ejected. He was rescued by his father in another PWC.

Discussion

Drowning is a primary cause of mortality in boat-related injury. A major risk factor for boat-related drowning is the lack of drowning-prevention measures, especially PFDs. However, PWC passengers have a lower percentage of drowning deaths when compared with other boat types. One reason points to the higher usage of PFDs. This study provides limited data on the ability of PFDs to preserve life and prevent drowning or near-drowning among PWC passengers.

In 38 cases, the only identifiable protective factor was the use of PFDs. This would estimate that 10 Arkansans are saved from premature mortality or life-long disability from near-drowning each year. Health professionals, educators, physicians and water-safety personnel should instruct clients and water enthusiasts on the advantages and benefits of PFDs in any water activity. ■

References

1. National Sporting Goods Association Sports Participation in 1995: Series II. 1995. Mt. Prospect, IL.
2. U.S. Department of Transportation,

United States Coast Guard. Boating Statistics 1996. Washington, D.C. Command Publication P16754.10, 1998.

3. Council of State Governments and National Association of State Boating Law Administrators. Reference Guide to State Boating Laws (First Edition). United States; Publication Code C139-9700; 1997.

4. U.S. Coast Guard. Draft regulatory evaluation: recreational inflatable personal flotation device standards. Washington, D.C., 1995.

5. Boat/U.S. Foundation for Boating Safety. Inflatable personal flotation device study: an examination of inflatable PFD performance and reliability in public use. Alexandria, VA, 1993.

6. Herrmann R, Stormer A. Results of recent research on life jackets. Journal of Royal Naval Medical Services, 1985; 71, 161-166.

7. National Safe Kids Campaign. The National Safe Kids Campaign Drowning Fact Sheet. October 1997: Washington, D.C.

8. Wintemute, GJ. Drowning in Early Childhood. Pediatric Annals. 1992; 21(7): 417-421.

9. Smith GS, Houser J. Risk factors for drowning: a case-control study. Abstracts of the 122nd Annual Meeting of the American Public Health Association, 1994; 323.

10. Hamman BL, Miller FB, Fallat ME, & Richardson JD. Injuries resulting from motorized personal watercraft. Journal of Ped Surg 1993; 28 (7): 920-922.

11. Vemberg D, Fine EG, Jagger J. Personal watercraft injuries. JAMA 1990; 261 :1883, (letter).

12. Francis RA; Vize R. Personal watercraft injuries: experience at a community hospital. Mo Med; 1994 May; 91 (5): 241-3.

13. Swinburn EE. Serious injuries in Jet Skiers. Med J Aust; 1996; 165 (11 - 12): 606-9.

14. Branche CM, Conn JM, Annett JL. Personal Watercraft-Related Injuries: a growing public health concern. JAMA; 1997; 278(8): 663-665.

15. Jones CS. Children and personal watercraft: injury characteristics and potential countermeasures. Injury Prevention; 1998; 4(1):61-61.

Jones is an assistant professor of health sciences at The University of Arkansas at Fayetteville.

Routine Procedure, Bad Outcome

J. KELLEY AVERY, MD



A 69-year-old man with a history of elective surgical repair of an aortic aneurism about 10 years before had complained of a nonproductive cough for three months. The cough was worse on mild to moderate exertion, but in the past few weeks had become progressively bothersome at night, preventing sleep. There was no history of hemoptysis. The patient had seen his primary care physician for this complaint about a month after it started.

There had been no unusual exposure to environmental irritants in the recent past, and he denied any hemoptysis. He had not suffered from allergies in the past, and although he had been a moderate smoker, he denied having smoked for the past 30 to 40 years. The physical examination was not revealing, and the chest X-ray taken in his doctor's office showed only some increase in the bronchovascular markings in both lower lung fields. Despite symptomatic treatment for the cough, it did not improve and, on the advice of his doctor, the patient agreed to an appointment with a pulmonologist for evaluation. At the time of the consultation, the specialist and the primary care physician agreed that a diagnostic bronchoscopic examination was indicated.

The patient arrived at the outpatient endoscopy center, having fasted for six hours as instructed, with a temperature 98.8°F, pulse 74/min and regular, respirations 18/min and blood pressure 124/74 mm Hg. The heart was normal to auscultation, and no murmurs or arrhythmias were detected. The chest and the abdomen were within normal limits. After the procedure was explained, the patient signed a standard informed consent document.

According to standing orders, at 12:15 p.m. the nurse administered 100 mg Demerol and

0.4mg atropine as preprocedure preparation. The patient was connected to a cardiac monitor that showed a normal sinus rhythm. A pulse oximeter on the patient's finger showed the O₂ saturation at 94% on breathing room air. According to standing orders, at 12:25 p.m. the nurse administered a 4% Xylocaine gargle in 15 cc of water, followed immediately by 15 cc of a 10% Xylocaine spray. (This was later changed and corrected to reflect that 10% Xylocaine spray of 60

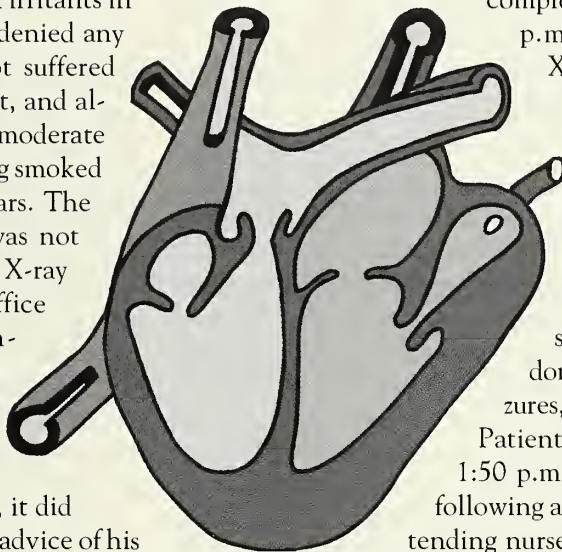
mg had been used, "due the rush to complete the chart.") At 12:45

p.m., 5 cc of 2% viscous Xylocaine was administered nasally. An IV of D5W in 0.5% normal saline was started, and the patient made ready for the procedure to begin.

The nursing record states, "Procedure not done. Code called due to seizures, and bradycardia at 1 p.m.

Patient transferred to hospital at 1:50 p.m." In a typed record, the following appears, "At 1 p.m. the attending nurse was called to the room, the patient having been found by the LPN

to have a monitored cardiac rhythm of 41. On stimulation the pulse responded back into the 70s, but immediately fell to the 40 range again. Seizure activity began. The attending physician and his attending nurse were called. The LPN turned the patient on his side as seizure activity continued. The patient became cyanotic and breathing stopped. Another physician attempted to intubate the patient and was unsuccessful. A pulmonologist responded to the code and intubated the patient. The resuscitation succeeded in restoring respiration and the cardiac rhythm remained in the 70s on O₂, via an ambu-bag while the patient was being moved to the hospital." Shortly after arrival in the hospital the patient went into ventricular tachycardia and was resus-



The physical examination was not revealing, and the chest X-ray taken in his doctor's office showed only some increase in the bronchovascular markings in both lower lung fields.

citated again. In the hospital a blood level of Lidocaine was found to be 23.8 µg. According to the PDR, a blood level of above 6 µg is considered to be at the low end of the toxic range.

This catastrophe was followed by a long (months) hospitalization during which he was ventilator-dependent for weeks. He was finally able to be extubated, and was transferred to a long-term care facility with severe cerebral damage. In the weeks and months that followed, much improvement occurred and the patient had become able to perform most of the functions of daily living. He was able to go to his home, but a significant memory defect remained.

A lawsuit was filed before the patient was moved to the long-term care facility, charging the attending physician and his group with negligence in failing to follow the existing protocol relative to the administration of Lidocaine, failure to properly monitor the administration of the medication, failure to properly attend the patient after the administration of the medication and causing the injury that resulted in severe brain damage.

Loss Prevention Comments

As in most medical malpractice cases there was a constellation of events that, when put together, furnished the basis for the legal action. The plaintiff patient acted against the physician and the group in which he practiced. The nurse who was employed by the group had been only recently hired, and it was learned on deposition that she had received minimal instruction in preparing patients for the bronchoscopic procedure. She stated that she had observed only two or three patients being prepared for it. There had been other complaints from members of the group about her performance in other areas of responsibility. It was learned that in this instance, after administering the Xylocaine in its various forms, she stepped out of the

room for a smoke, leaving the patient unattended.

She was terminated shortly after this event. The outpatient record was inadequate to describe the entire process of preparation, which did not totally follow the existing protocol, particularly in respect to the need for close observation following the administration of Xylocaine and the requirement of physician supervision during the preparation process.

From the existing record, it was argued that neither the nurse nor the attending physician was immediately available when the patient developed bradycardia and, subsequently, seizure activity. Another pulmonologist and group nurse responded to the emergency. A third group physician attempted to intubate the patient but failed. The responding pulmonologist was quickly successful in getting an airway established. The IV was started, and the patient was quickly transferred to the hospital. The record did not estimate the time during which the patient was without adequate ventilation. The transfer to the hospital took only a matter of minutes, since the group's endoscopic center was on a floor of the physician's office building that had direct access to the hospital itself.

From the patient's perspective, what had been described as a routine and relatively simple procedure became a life-threatening emergency necessitating a prolonged recovery in the hospital, the long-term care facility and at home. Although the patient recovered remarkably, a significant memory deficit persisted.

The lessons to be learned in this case involve systems of care in the outpatient arena and the physician's facility — systems that were never prop-

**As in most
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erly in place or were not followed. In this instance: (1) Although a protocol did exist, it was not thought to be adequate by experts reviewing the case, and (2) in addition, it was not followed: (3) The nurse assigned to the preparation of the patient had not been adequately trained in the first place and had been the subject of complaints by other members of the nursing staff because of her observed unprofessional behavior. This had not been addressed by the management of the group. The other common sense requirements and expectations of (4) close observation and (5) physician su-

pervision were not observed by either the nurse or the physician. From the outpatient record, the exact dose of Xylocaine administered could not be established, but the blood level of the drug of 23.8 µg reported in the hospital at least an hour after the preparation of the patient could not be explained except by the patient receiving too much of the drug.

In the preparation of this case, no experts could be found who would state that the expected standard of care was followed. A large settlement was required to close the legal action. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it difficult to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the Journal of the Tennessee Medical Association in July 1998. It is reprinted with permission.

Tuberculosis Rises in Homeless Shelters

KASHEF IJAZ, MD, MPH
JOSEPH H. BATES, MD, MACP



Tuberculosis (TB) is an infectious disease caused by *M. tuberculosis* and transmitted through air in the form of small droplets when an infectious TB patient speaks, sneezes or coughs. TB can be transmitted in various settings ranging from normal households, churches, bars, trains and airplanes to high-risk facilities such as prisons, jails, drug treatment centers, nursing homes and homeless shelters.

In the high-risk facilities, TB can go undetected allowing transmission of TB infection, which can result in new cases of active TB. In Arkansas, we have had excellent TB control, but despite an aggressive program in the state, there have been instances when an undetected TB patient caused transmission of *M. tuberculosis*.

In September 1998, a local health unit in city and county A in the northeastern part of Arkansas recognized a greater than normal number of TB cases (12 vs. an average of 7). On further investigation, it was discovered that most of these TB cases were from a homeless population.

TB Case and Contact Investigation

The Tuberculosis Program, Arkansas Department of Health, received a call from Kentucky relating that they had discovered a TB patient (Patient A) who had come from Arkansas in their homeless shelter. This happened as part of a contact investigation, which was being carried out for another TB patient at that shelter in Kentucky. This triggered a TB contact investigation in Arkansas, which centered around a homeless shelter (Shelter A) in city and county A. On the first round of tuberculin skin testing (TST), the employees of the shelter along with the residents were screened and eight of 19 people tested positive for TST. The high number of positive skin tests meant that transmission had been going on in

the shelter for quite some time.

Patient A was highly infectious (smear and culture-positive), non-compliant and difficult to treat. As a result of his refusal to take TB medication, Kentucky TB authorities transferred him to a TB confinement facility in Mt. Vernon, Mo., where he was given directly observed therapy (DOT) for tuberculosis until he had negative sputum smears. After completion of this initial therapy, he moved to city and county A in the northeastern part of Arkansas where there was noted to be an ongoing increase in the number of TB cases in the homeless population. In Arkansas the patient was met by a dedicated TB

public health nurse who had arranged housing where he would stay until completion of his treatment.

On further investigation it was found that Patient A had stayed at Shelter A from February '97 until August '97. It also was found that his brother was diagnosed as having TB in January '97 in another county. When the TB contact investigation was done for his brother, it was learned that Patient A had recently moved out of his brother's house and moved to city and county A and had not been TB skin tested at that time. The question arose: Could patient A be the source case for the other cases in Shelter A?

(Continued on page 103)

Reported Cases of Selected Diseases in Arkansas

Profile for May 1999 - The 3-month delay in the disease profile for a given month is designed to minimize any changes that may occur due to the effects of late reporting. The numbers in the table below reflect the actual disease onset date, if known, rather than the date the disease was reported.

Disease Name	Total Reported Cases YTD 1999	Total Reported Cases YTD 1998	Total Reported Cases YTD 1997	Total Reported Cases 1998	Total Reported Cases 1997
Campylobacteriosis	61	51	55	179	175
Giardiasis	74		63	168	220
Salmonellosis	126	91	74	616	445
Shigellosis	42	1	61	211	273
Hepatitis A	2		120	82	223
Hepatitis B	23	46	39	115	106
Hepatitis C	2	2	3	10	5
Meningococcal Infections	19	22	25	31	38
Viral/Aseptic Meningitis	8	5	10	77	26
Ehrlichiosis	1	5	3	14	22
Lyme Disease	1	4	8	8	27
Rocky Mtn Spotted Fever	4	9	8	23	31
Tularemia	4	9	9	26	24
Measles	0	0	0	0	0
Mumps	0	0	0	13	3
Chlamydia	2,302	1,419	1,007	4,127	2,554
Gonorrhea	1,090	1,596	1,927	3,962	4,388
Syphilis	82	112	241	294	394
Pertussis	5	15	5	93	60
Tuberculosis	62	42	80	171	200

For a complete list of reportable diseases in Arkansas, call the Arkansas Department of Health, Division of Epidemiology, at (501) 661-2893 during normal business hours.

PEOPLE+EVENTS

HONORED

Dr. France Named Chairman of MedCamps

Dr. Gene L. France, a Little Rock allergist, is the new chairman of Medical Camps of Arkansas Inc., which provides camping activities for children with medical problems.

Other officers are Dr. Gilbert A. Buchanan, vice president; Dr. Betty A. Lowe, secretary; and Dr. Kelsy J. Caplinger, treasurer and past chairman. The immediate past chairwoman is Dr. Eileen Ellis.

MedCamps has served 6,194 campers at Camp Aldersgate since it began in 1971. It's a nonprofit project of the Arkansas Chapter of the American Academy of Pediatrics.

OBITUARIES

Dr. Neil E. Compton

Dr. Neil E. Compton, 86, of Bentonville died Feb. 10, 1999.

Dr. Compton, born Aug. 1, 1912, was a 1939 graduate of the University of Arkansas College of Medicine.

Dr. Compton was known widely for his opposition to dams along the Buffalo River in the 1960s. He was one of the organizers of the Ozark Society which, along with several state and national politicians, halted plans by the Army Corps of Engineers to create impoundments. The Buffalo River became the country's first national river in 1972.

Dr. Compton compiled his experiences in a book, "The Battle for the Buffalo River."

Dr. Aaron C. Modelevsky

Dr. Aaron C. Modelevsky, 88, of Jonesboro died March 6, 1999.

Dr. Modelevsky, born Dec. 12, 1910, was a 1934 graduate of the University of Minnesota Medical School. He first practiced medicine in Arkansas in 1940. He is survived by his wife, Peggy.

Dr. Thomas R. Jackson

Dr. Thomas R. "Tommy" Jackson, 46, of Conway died June 21, 1999.

Dr. Jackson, born Dec. 23, 1952, was a physician at the Little Rock Medical Clinic. He was a graduate of the University of Arkansas for Medical Sciences. He is survived by his wife, Dr. Carole Bryant Jackson, three sons and a daughter. ■

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(Continued from page 101)

Combining Conventional Epidemiology, DNA Results

To investigate this matter further, we combined conventional epidemiology with results of DNA fingerprinting patterns of the infecting strain of *M. tuberculosis* isolated from the patients involved.

We reviewed all culture-positive TB cases in city and county A since 1994. There had been a total of 48 TB cases since 1994 and 28 (58.3%) could be grouped into four DNA fingerprinting clusters; one of these (cluster 1) contained 12 TB cases, all from shelter A including patient A. This meant that all 12 of these patients were infected with the same strain of *M. tuberculosis* since each isolate had an identical fingerprint pattern.

To determine the chain of transmission of tuberculosis and ascertain the epidemiological linkages among patients in cluster 1, we prepared a timeline for all patients setting out onset of TB symptoms, tuberculin skin test results, smear and culture positive results, chest X-ray readings and date of start of treatment. We also conducted detailed epidemiologic interviews for all patients in the cluster.

The timeline data together with the

epidemiological information obtained from interviews found epidemiological linkages for all but one patient in cluster 1, she being an incoherent, elderly, nursing home patient (Patient B) who had never been in a homeless shelter. All other patients had epidemiological links among themselves and all had stayed in shelter A. Patient A had stayed at shelter A from February '97 until August '97 when he moved to Kentucky (where he was detected as a TB case). Two of his friends with whom he had lived in the shelter also developed tuberculosis and are part of cluster 1 (Patient C and D).

Discussion

Patient A was a highly infectious undetected TB patient in shelter A from February '97 until August '97 where he transmitted TB infection that resulted in numerous positive TSTs and eight additional TB cases, of which one was HIV-positive and died. There can be grave consequences of having undetected tuberculosis, and this outbreak clearly demonstrates the need for active surveillance and screening in high-risk settings.

However, there are difficulties in conducting active surveillance and TB screenings in these settings. The problems range

from lack of trained personnel to do screenings at these shelters to difficulty in obtaining follow-up of the homeless individuals. In spite of these difficulties, the TB Program has established an active surveillance program at homeless shelters, drug treatment centers, jails, nursing homes and prisons. It is recommended that the inmates, residents and employees of these facilities be regularly tuberculin skin tested on entry and then annually. Public health nurses, communicable disease nurse specialists, TB case managers, chest clinicians and TB central office support staff provide comprehensive training and TB education for all high-risk facilities. UV-lights are installed in these facilities where feasible. Despite all these measures, all health care professionals must "Think TB" when caring for patients who have suspicious chest X-rays or prolonged episodes of pneumonia that do not respond to conventional therapy. ■

Dr. Ijaz is a medical epidemiologist in the Division of Tuberculosis at the Arkansas Department of Health. Dr. Bates is director of the Division of Tuberculosis at the Arkansas Department of Health and a professor of medicine at the University of Arkansas for Medical Sciences.

**Sept. 22-23, 1999
AMA Grassroots
Conference**

The Mayflower Hotel in Washington, D.C., is the site for this American Medical Association conference on managed health care and federal regulation. To find out more or to register, call (800) 621-8335 or see the web site, www.ama-assn.org/politicaleducation.

**Oct. 17-21, 1999
ACOEM State-of-the-Art Conference**

The theme of this year's American College of Occupational and Environmental Medicine conference at the Hyatt Regency San Antonio is "Challenges and Controversies in Occupational Medicine."

CALENDAR

It's open to all occupational and health professionals and will include postgraduate seminars, technical exhibits and guests. Four two-day preconference professional development courses will be offered, too.

For info: call ACOEM, (847) 818-1800, ext. 389, or see the web site, www.acoem.org.

**Oct. 23, 1999
New Techniques in
Urinary Incontinence
and Female Urology**

The division of urologic surgery at Washington University's School of Medicine presents this seminar at the Eric P. Newman Education Center in St. Louis. The seminar will

feature a live case demonstration of transabdominal sacrocolpopexy.

For info: call (800) 325-9862 or send e-mail to CME@msnotes.wustl.edu.

**Oct. 28-30, 1999
Current Topics in
Cardiothoracic
Anesthesia and
Contemporary
Cardiothoracic Surgery**

These two seminars will run concurrently at the Eric P. Newman Education Center at Washington University Medical Center in St. Louis.

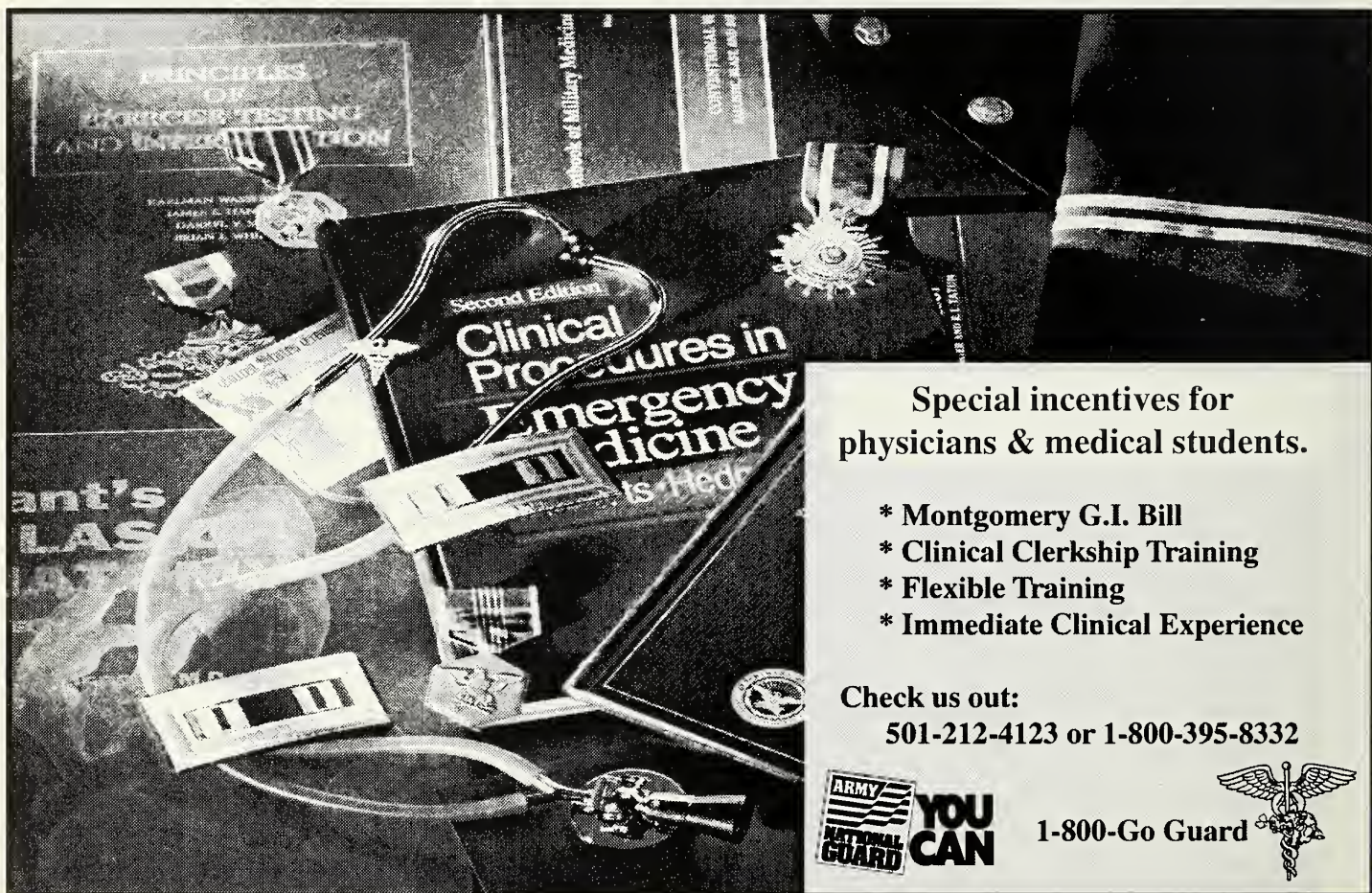
"Current Topics in Cardiothoracic Anesthesia" and "Contemporary Cardiothoracic Surgery" will be presented by the

school's division of cardiothoracic anesthesia and division of cardiothoracic surgery, both part of Washington University School of Medicine's continuing medical education department. The courses update the pathophysiology, diagnosis and management of a wide range of circulatory and pulmonary problems in adult patients.

For info: call (800) 325-9862 or send e-mail to CME@msnotes.wustl.edu.

**Nov. 4-7, 1999
National Kidney
Foundation Annual
Meeting**

Call (800) 622-9010 for more information about this gathering in Miami, or check the foundation's web site, www.kidney.org. ■




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Vol. 96 No. 4

September 1999

Women in Medicine Month:

Profiles Celebrate
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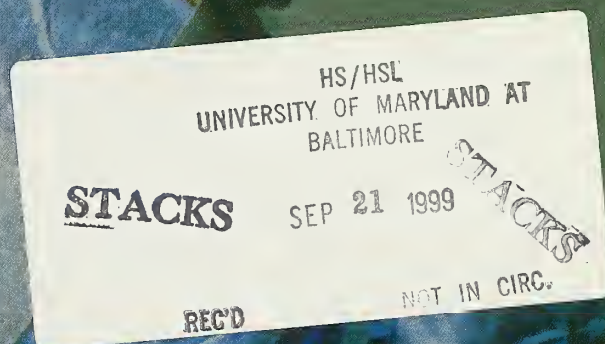
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- 120 Women in Medicine**
September is Women in Medicine Month. In this issue we profile some of Arkansas' top women physicians, including an up-and-coming medical student.

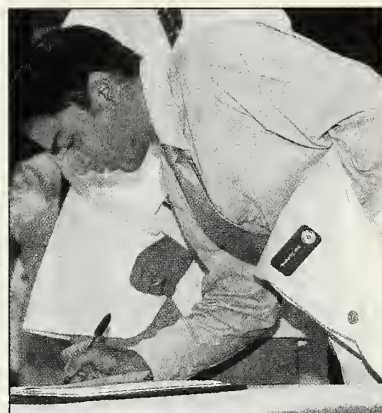
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COMMENTARY



Women Patients Have Specific Needs

VICKIE HENDERSON, MD

September is women's health month and this issue of *The Journal of the Arkansas Medical Society* is dedicated to women's health issues. Some of the health issues that affect women are shared with men and some are unique to women. Below I have outlined some of my observations, but please keep in mind I only have female patients. Some of you already know these things, some of you may need to be reminded and some of you may not be interested. I'm sure that some of you will disagree with my generalizations, but this is intended to be a salute to the characteristics that make women unique and the doctors — both male and female — that provide health care to them.

1. Women get pregnant. I know you already know this, but I want to remind you that women get pregnant. Women who are 40 and up get pregnant, and "women" who are 12 get pregnant. And every woman in between gets pregnant. This is important for you to know if you are a pediatrician, an oncologist, an internist or whatever.

Sick women get pregnant too. Women with diabetes mellitus, women with seizure disorders and yes, even women with cancer get pregnant. Unfortunately, the sickest women of all are sometimes the very ones who conceive. Most often it is unintentional and brings an added complexity to the patient's disease. Occasionally, the treatments that we prescribe can interfere with contraception. For example, patients on anticonvulsants may need a higher dose of oral contraceptives. Women also need to know what to do about their birth control pills when they have surgery and they are going to be NPO for several days. And we all know that certain antibiotics may interfere with the effectiveness of oral contraceptives, but do we remember to tell our patients?

2. Women worry. I bet you already had this one figured out, but it is important to recognize. Mothers worry about their children, wives worry about their husbands and daughters worry about their mothers. We can't help it, it's the way we are. Women also worry about their own health. Granted men worry too, but women are more prone to attribute a minor symptom to a serious illness, whereas men are more likely to ignore warning signs. Therefore, it's important to be sensitive to this issue and realize that if you say the word "biopsy," you ought to say "cancer," because she's already thought it. Most frustrating of all is that women want you to read their mind and reassure them about their concerns even if they haven't voiced them.

3. Women are versatile. They have many roles to play. They often work full time, clean, cook, care for their children and involve themselves in church and community activities. Of course, men often have just as many irons in the fire. But women are less inclined to recognize the value of rest and relaxation, never taking personal time for themselves. Of course this is a great generalization, but there is no doubt that trying to be a career woman, mother and wife can be very demanding and can have a great impact on a woman's health — physical, mental and emotional. She may neglect to exercise, take calcium supplements or do self-breast exams.

4. Women cry. This is a terrible stereotype but is often a reality. Women cry when they are sad, happy, scared or mad. Sometimes women cry for no reason at all, especially in the doctor's office. ■

Dr. Henderson is a member of the editorial board for the The Journal of the Arkansas Medical Society and is a OB/GYN with the Millard-Henry Clinic in Russellville.

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The Arkansas Medical Society has been intimately involved in what seems to be a "never-ending saga" of passing a Patients' Bill of Rights in the United States Congress.

Patients are demanding action, yet Congress continues to make this the biggest political game in town. However frustrating this battle becomes, we are dedicated to, and must continue our efforts to, return health care decision-making back to the hands of patients and their physicians. The health insurance industry committed \$20 million to defeat any strong patients' rights legislation. Mark Merritt, chief strategist for the American Association of Health Plans, said, "We will spend as much as it takes."

The medical community and patients can never match the insurance industry's money, but we can outwork them on the grassroots level.

An article in the July 14 issue of the *Arkansas Democrat-Gazette* reported that Sen. Blanche Lincoln, D-Ark., was wavering on the Senate proposal that would hold health maintenance organizations accountable for their medical decision-making. The AMS put out an emergency legislative alert to key physicians asking them to contact Sen. Lincoln immediately, expressing their displeasure. Below are examples of two letters/e-mails that were sent to the senator. Sen. Lincoln's staff indicated they received many constituent communications on this important issue. We don't know how much impact our grassroots effort had on her vote, but on July 15 she cast the right vote for America's patients. Our thanks goes out to Sen. Lincoln and especially to all of the AMS members who responded to our call to action. ■



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July 14, 1999

The Honorable Blanche Lincoln
708 Hart Senate Office Building
Washington, DC 20515

Dear Blanche:

I can't tell you how dismayed I was when I read this morning's headlines in the *Democrat/Gazette*! Unlike Wal-Mart, Arkansas physicians don't have the luxury of having someone "camp out" in Washington to spend full time opposing managed care reform. Arkansas physicians are home treating patients and constantly trying to work with them through the maze of managed care abuses.

Senator, at one time Arkansans merely heard the anecdotal horror stories from the East and West Coasts...now, we're living them.

Quite frankly, the 4000 doctors I represent and their patients don't understand why HMOs are the only organizations in America that cannot be held accountable for their mistakes. And, believe me, they are making medical decisions that affect patient care everyday. The opposition's claim that this increased liability will result in a proliferation of lawsuits is just not true. In the giant state of Texas that passed an "insurance company responsibility act" it has not resulted in a flood of lawsuits. It has, however, created a sentinel effect whereby insurance companies are being more responsible because they know that they can and will be held more accountable!

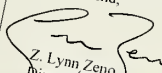
I know that you have been inundated with information on both sides minutely detailing the differences in the various proposals. Certainly there are some troubling sections in the language of both proposals. Unfortunately, this just goes with the complexity of federal bill drafters. We do it much more simple in Arkansas. However, we can only express to you our key concerns in bullet points and trust that you will use your wisdom and compassion to see that they are included.

Again, here are the key provisions that we plead with you to have included in the final bill:

- **Medical Necessity**- Ensure that doctors have the final say over what is deemed "medically necessary" when treating patients.
- **External Review**- Give patients the ability to appeal a health plan's decision through an independent, fair, and timely external review process.
- **Accountability**- Managed care plans should be held accountable if their decisions harm a patient.
- **Protections for All Americans**- patient protection legislation should apply to all private health insurance, not just ERISA plans.
- **States' Rights**- Don't let the federal government override or undermine the patient protection laws that we have already passed in Arkansas.

Senator, health care cost were skyrocketing and had to be brought under control. Unfortunately, as is often the case, the pendulum has swung too far in the other direction. Managed care has deteriorated into a "profits first, patients last" system. The only way to heal the system is to ensure that quality care for patients becomes paramount.

Your friend,


Z. Lynn Zeno
Director of Governmental Affairs

David Ivers

12 Markwood Drive
Little Rock, AR 72205
501-224-9708 fax: 501-375-1940

July 14, 1999

via facsimile 202-228-1371
Hon. Blanche Lincoln
United States Senate
Washington, D.C.

Dear Sen. Lincoln:

I was shocked when I read your comments in the *Arkansas Democrat-Gazette* today. I cannot believe you have been boonswaggled by the HMOs and big business. Are you really more concerned about protecting gigantic corporations like Wal-Mart and Blue Cross over the patients who, year after year, are left suffering or even dead as a result of negligence by HMOs? Everyone else, including you and I, are legally responsible for our negligence, so why should HMOs be any different. Yes, it might cause a small increase in premiums, and HMO execs might see their big bonuses squeezed a little, but that is a small price to pay.

In urging you to vote for the Democrats' Patients Bill of Rights, I have reprinted below part of a letter written by Rep. Greg Ganske (a Republican!) to the Wall Street Journal on August 19, 1998:

Lamenting his ability to provide relief to a deserving plaintiff, Federal District Court Judge Charles Pickering wrote, "There has not been a single case that has been filed before this court by an employee coming into federal court saying, 'I want to protect my pension or my benefits under the broad terms of ERISA.' Every single case brought before this Court has involved insurance companies using ERISA as a shield to prevent employees from having the legal redress and remedies they would have had under long-standing state laws existing before the adoption of ERISA. It is indeed an anomaly that an act passed for the security of the employees should be used almost exclusively to defeat their security and leave them without remedies for fraud and over-reaching conduct.

Please do the right thing.

Sincerely,


David L. Ivers

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100 YEARS AGO

Progressive Medicine

Mr. President and Gentlemen: I suppose that I ought to offer an apology in advance for my paper, as it is merely an effort at medical literature, not a scientific paper at all — but merely an effort at medical literature, progressive medicine.

The day for blind credulity has passed, and on all sides it is admitted that we are at liberty to ask certain questions in regard to the books and their authors — questions which an earlier and more intolerant age would not have allowed.

As late as 50 years ago we would have been considered heretical, in the estimation of those who believed that medicine was a scaled book, if we had used the microscope in bringing forward some of the mysterious causes of disease. Whether the investigations will ever prove satisfactory to the investigators is yet *sub judice*, to use a legal term.

In my opinion the attempt to make medicine a definite science will no more be accomplished than it would be in theology or law.

If the three learned professions have moved pretty well on a parallel; if either have gotten the advantage, we would give it to medicine, speaking in a temporal sense. Medicine has done more good for the masses, by its charitable acts, by its pure principles of unselfish deportment, by recognizing no distinction in race or color, rich or poor, bond or free.

So from time to time the world arouses to the fact that a great advance has been made; the old has partially passed away, and with it has gone some of the ignorance and superstition of former generations. ■

Reprinted from the "Proceedings of the 24th AMS Annual Session," May 1899.

I N + T H E + N E W S



Hot Springs Clinic Drops Blue Cross

Physicians with HealthFirst Physicians of Arkansas, P.A., of Hot Springs said they will drop Arkansas Blue Cross and Blue Shield, the state's largest health plan network.

HealthFirst physicians said Blue Cross has restricted them to the point they can no longer do business with the health plan. The Hot Springs clinic includes 34 physicians. Richard Grisso, HealthFirst's chief executive officer, said Blue Cross has made it impossible for physicians to provide emergency and after-hours care, ultimately jeopardizing the quality of patient care. Some HealthFirst physicians also have been excluded from the Blue Cross network.

Holt-Krock Clinic Purchase Closes

The sale of the Holt-Krock Clinic in Fort Smith to Sparks Regional Medical Center closed in August, creating one of the region's

largest health system.

Sparks bought the clinic from PhyCor Inc. after a slew of lawsuits were filed by clinic physicians against the physician practice management company based in Nashville, Tenn. To keep from losing many physicians in the community, Sparks decided to purchase the clinic from PhyCor. The three entities have been in discussions since 1997.

The resulting Sparks Health System includes the region's largest physician group representing the greatest number of specialties, subspecialties and practice sites in the area; the community's largest hospital; 2,800 health care employees; three rural health clinics; Booneville Community Hospital; a home health program; PremierCare, the largest sponsored managed care organization in the state; Sparks Development Foundation; Marvin Altman Fitness Center; and Sparks Athletic Club.

"We believe the Sparks Health System represents the best and brightest in health care — from primary to specialty

care, from inpatient to ambulatory services and from physician residency training to clinical research all in a community-owned and operated, not-for-profit system," said Michael Helm, president of the Sparks Health System.

Helm says the merger of the hospital and clinic will eliminate duplicated services in the community, boost a fully integrated information system, increase purchasing and contracting power and help recruit new physicians to the area.



Groups Combine Credentialing Systems

The American Medical Association and the National Committee for Quality Assurance have signed an agreement that will reduce the duplication in the credentialing of physicians by health plans.

Under the plan, managed care organizations that use data from the AMA's American

Medical Accreditation Program may rely upon such data as being in full compliance with the relevant NCQA managed care organization credentialing standards. In addition, an MCO may use an AMAP accreditation survey report in lieu of an office site visit.

The new agreement is expected to lead to more consistent information, resulting in cost savings for health plans, employers and physicians.

The NCQA also certifies credentials verification organizations. AMAP will contract only with NCQA-certified CVOs certified for physician credentials data. Through the agreement, NCQA will establish a CVO Standards Advisory Committee, which will be responsible for recommending the standards and scoring used by the NCQA to certify CVOs.

Each physician who applies for AMAP accreditation is evaluated against national standards in five areas: credentials, personal qualifications, environment where the care is provided and medical records, clinical process and patient outcomes. ■

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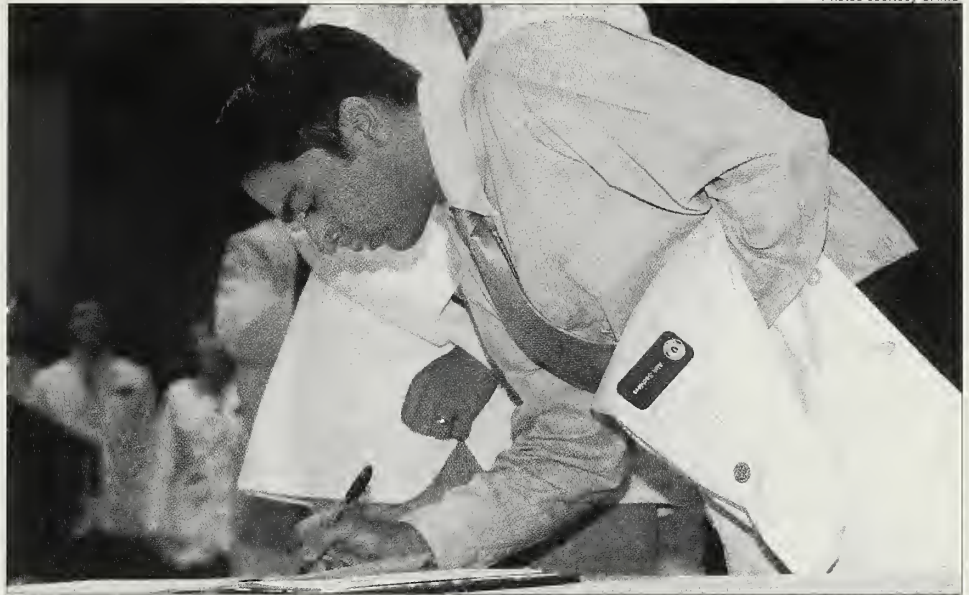
New UAMS Students Take Oath of Honor, Don White Coats

Photos courtesy: UAMS

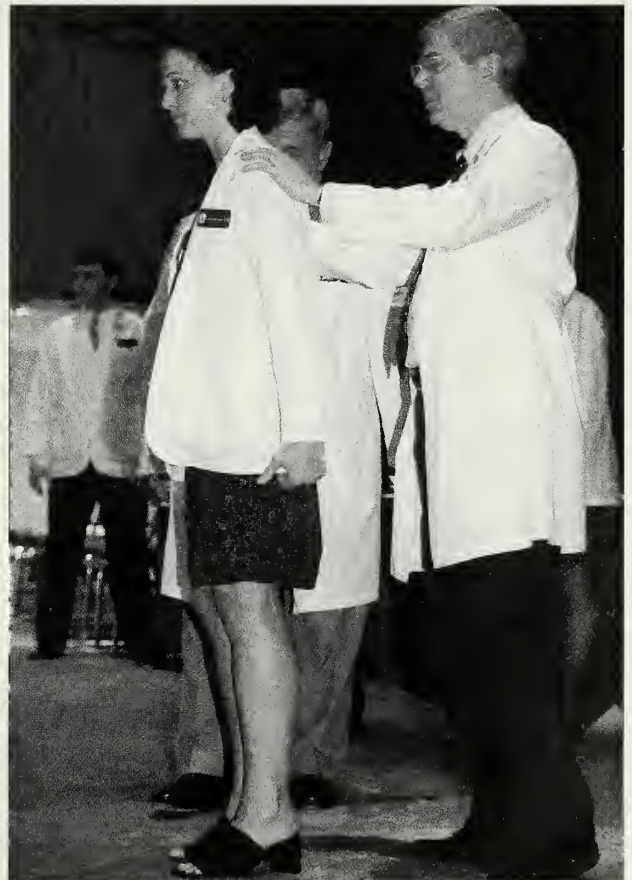
August marked the first week of medical school for 150 students at the University of Arkansas for Medical Sciences. The students were chosen from 400 applicants. During orientation week students learned about what to expect during their four years of study, the ethics medical students must abide by and when is the best time to decide on a speciality.

The highlight of the week was the White Coat Ceremony, which several AMS members took part in. Students take an oath of honor and receive the short, white jackets they wear throughout medical school.

This year's freshman class is 67% male and 33% female. The youngest student is 20, the oldest is 45; 81% are between the ages of 20-24. Eighty-eight percent of the class is white, 6% is Asian-American, and 4% is African-American. Seventy-nine percent of the students graduated from Arkansas universities and 21% attended out-of-state schools. ■



First-year student Alan Schadeva registers for classes.



Joanne Price receives her white coat from Dr. Richard Wheeler, associate dean for student and academic affairs at UAMS.



Jessica Causbie receives her Code of Professional Conduct for Medical Students from Dean Wilson.

Women in Medicine

By Natalie Gardner

Gaining Ground, Becoming Leaders

For a long time, the world of medicine was a man's world. If women wanted to care for patients, then they were nurses, not doctors. But the role of women in medicine has drastically changed and is increasing everyday.

September celebrates those women and their growing number of achievements. Although not as active in leadership roles in the past, women physicians are changing that. In the past couple of years, the American Medical Association created the AMA Women Physicians Congress to help expand the role and influence of women in organized medicine, as well as address critical women's health and professional issues. Last year, the AMA voted for its first woman president, Dr. Nancy Dickey, a family practice physician from College Station, Texas.

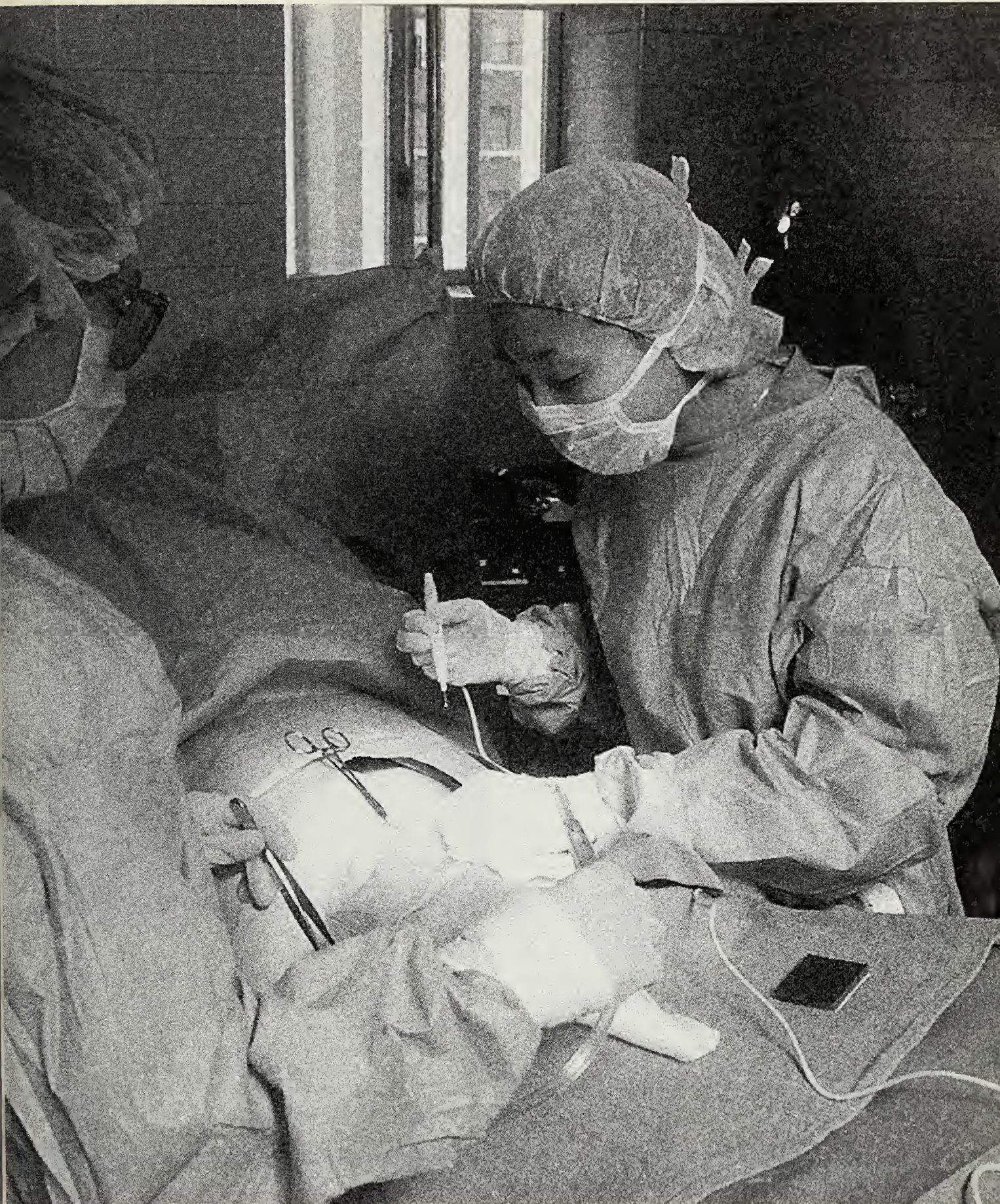
According to the AMA, in 1970 the United States had 92.4 percent male doctors and only 7.6 percent female physicians. In 1996, there were 78.7 percent male physicians and 21.3 percent female physicians.

Much progress has been made in increasing the number of women doctors, but the field is far from equal for women and men. Pay, for instance, varies widely: In 1995 male physicians earned an average income of \$205,800, compared with female doctors who earned an average of \$143,300. The financial disparity is the result of numerous factors, including the reality that many female physicians are employees rather than self-employed doctors. Additionally, female physicians are overrepresented in the lower-paid specialties; they tend to see fewer patients (spending more time with each patient); and they have less experience than their male counterparts.

The number of women applicants to U.S. medical schools is continuing to grow, with almost 43 percent of the U.S. medical school applicant pool women in 1995-96, according to the Association of American Medical Colleges. Women made up almost 42 percent of the total enrollment in U.S. medical schools in 1995-96.

On the next few pages, you'll meet some of Arkansas' top female physicians, as well as an up-and-coming medical student. These six women are entrenched in Arkansas' health care community and continue to help make the state a healthier one. ■





Professor Juggles Family, Research, Teaching

By Natalie Gardner

Dr. Klimberg Hands Credit for Success to Mentors, Co-Workers

Dr. Suzanne Klimberg's curriculum vitae is page after page of awards and honors, board appointments, research grants and published papers.

Dr. Klimberg — director of women's oncology at the Arkansas Cancer Research Center, part of the University of Arkansas for Medical Sciences system — also is the mother of two girls, 6 1/2 months and 14 months old, which makes her accomplishments even more amazing.

"You really have to work hard to become a doctor," she said.

Dr. Klimberg was named a full professor last year, making her the only female professor in surgery at UAMS. She is part of 8% of the professors in the University of Arkansas system that are women. She is director of the medical school's Women's Health Center, as well as a member of the Southwestern Oncology Group's Committee on Women's Health Advisory Board. She is the second woman to be named president of the Association of Academic Surgery, the second-largest surgical association in the country. She is the third woman to be inducted into the Southern Surgical Association.

Dr. Klimberg is quick to credit her success to the many co-workers and mentors that surround her. She rattles off half a dozen names right off the top of her head, people who have helped her with breast cancer research and efforts to improve women's health: Maureen Colvert, who works on the breast cancer prevention trial; Dr. Ronda Henry-Tillman, Dr. Klimberg's newest partner in breast surgery; and her current mentor, Dr. Shirley Gilmore, who recently stepped down as chairman of the anatomy department at UAMS.

"We've finally got a critical mass," Dr. Klimberg said. "No one could do this alone. We just have a great program here."

Strong Role Models

Mentoring is an important aspect of Dr. Klimberg's career. She has had several over the years through medical



school at the University of Florida College of Medicine to her residency in the department of surgery at Florida to her fellowship in breast diseases at UAMS.

"I think it's important to have people to mentor you," Dr. Klimberg said. "We had one woman on the faculty at the University of Florida. Now there are many more women, but all that time there, I had no role models. Things are different now. Dr. Gilmore is my mentor and now I can mentor other people along the way too, like Dr. Henry."

Dr. Klimberg meets with Dr. Gilmore periodically to

talk about management issues, such as how to handle people and certain situations. They also talk about how to survive in a predominately male world. Dr. Gilmore is no stranger to that; she has fought numerous battles climbing the career ladder.

Ongoing Research

With her numerous leadership roles and two young children, it's hard to believe the progress Dr. Klimberg has made in breast cancer research.

One of the biggest projects her department is focusing on includes the Star Trial, a prevention study comparing the effects of two drugs, tamoxifen and raloxifene, on reducing the occurrence of breast cancer in postmenopausal women age 35 and older who are at risk for the disease. Before this trial, Dr. Klimberg and her crew studied tamoxifen and found the drug decreases the risk of breast cancer by 50 percent.

The department also is part of a national clinical trial focusing on lymph node preservation. The team is working to get funding from various sources, including the Susan G. Komen Breast Cancer Foundation, to get the trials out to private practices so more women can participate in them.

Breast cancer research and surgery have always been passions of Dr. Klimberg's.

"Breast has so many things to offer," she said. "First of all, it's very exciting the advances we are making — rapidly. Breast surgery in itself is not difficult, but we're doing so many new things that even simple, minor things make a big difference for the patient — less trauma to the patient, less side effects.

"There's so many advances, especially thinking about it from a woman's perspective, which I can do. There's a little plastic surgery in it, a little psychology because it's devastating to people and science, in that we're making advances all the time. I'm also a biochemist, so what we're doing in the

laboratory fits into what I'm doing clinically. I just couldn't be more thrilled to be able to do what I'm doing."

Improving Women's Health

Another passion of Dr. Klimberg's is the UAMS Women's Health Center, which she directs. The center is working to identify and promote comprehensive clinic services with one-stop shopping for patients. Services would include comprehensive preventive care for the high-risk patients, research into women's health issues and education and mentoring of female physicians and scientists.

Arkansas' poverty level is 49th among the 50 states. Fifteen percent of the state's population lives below the poverty level, compared with 13.8% nationally. Many of the women physicians and faculty members at UAMS have volunteered with the center and are anxious to start helping some of the state's more high-risk women patients, Dr. Klimberg said.

The goal of the center also is to use telemedicine in these one-stop clinics. An example of this is being able to share the medical school's genetic counselors at high-risk clinics across the state through advanced technology.

Growing Numbers

Although women make up 8% of UAMS' full professors, Dr. Klimberg believes that is changing, with more women stepping into leadership roles.

"I think the dean and chancellor have been kind in giving women the chance to step up," she said. "There's more women breaking through. It's easier today than how people like Dr. Gilmore had it."

But Dr. Klimberg says there is still a way to go when the field of medicine will look balanced. The key, she said, is having role models. Women physicians who have made it to the top need to mentor others, helping younger physicians to lead. ■

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Personal Touch Leads to Successful Practice

By Judith M. Gallman

Women Partners Bring Insight to Female Maladies

The Arkansas Clinic for Women doesn't look like a typical clinic.

Oriental rugs lay along shiny hardwood floors in the reception and waiting room areas, where gilded mirrors and impressionist paintings hang above claw-footed bureaus and sofas. The colors are warm beige, deep maroon and soothing forest green, and they blend nicely with tasteful upholstery, chandeliers and sconces. Examination rooms aren't impersonal cubicles; each one is comfortably-appointed with cheery curtains hung in a corner to afford patients privacy. There are other feminine touches: cherubs, padded foot covers and televisions with cable and a remote control patients can use while waiting.

This clinic is an obstetrics/gynecology clinic run by women for women, one of three such clinics in Little Rock. Physician partners are Judy McDonald, Pamela J. Wills and Peggy K. Guard. The clinic, now in Medical Towers One, has grown by leaps and bounds since Dr. McDonald began a practice in 1988 at the Doctors Building. She moved to Medical Towers One in 1992.

Dr. McDonald, 48, a divorced mother of four who raises thoroughbred horses, said she chose women partners because she felt more comfortable practicing medicine with women.

"We function well together," Dr. McDonald said of her current partners.

Dr. McDonald, soft-spoken and intense, has a calm, laid-back demeanor, while Dr. Wills, vivacious and giggly, brings a high level of enthusiasm to the practice. Both are compassionate, caring health care providers.

In obstetrics and gynecology, Dr. McDonald pointed out, many women feel more at ease seeing a female physician who brings a personal touch to the



Dr. Pamela Wills (left) and Dr. Judy McDonald.

Photo: Spencer Tirey

bedside. The homey office decor also relaxes patients, something a cold, clinical setting rarely does, she and Dr. Wills agreed.

"Women do seem to appreciate it. They do feel more at ease," Dr. McDonald said. A few women, however, do not feel comfortable using a female physician, she said.

The OB/GYN world has changed dramatically over the last 20 years, Dr. McDonald said, estimating OB/GYN resi-

dencies in Arkansas are mostly filled by women, while the mix was 50 percent male-female 15 to 20 years ago. Female medical students, once reluctant to take on the challenge of surgical-oriented specialties because of a built-in bias against women, have few qualms today about jumping into operating rooms.

The partners often consult with each other, and because obstetrics is a large part of their business, it is not uncommon to find them in the OR together.

Patient needs, too, have changed over the years, the doctors said. Menopause, hormone replacement issues and hysterectomies remain important female health issues, but more and more women want help with sexual problems, including decreased libido or pain associated with intercourse, the doctors said.

"Hardly anyone was talking about it two years ago," Dr. Wills said, estimating that a majority of her current patients need help with sexual difficulties. Stress and low-grade depression take their toll on young and older women alike, Dr. McDonald said.

Marital problems, premenstrual syndrome, migraines associated with PMS, breast cancer, cervical cancer and infertility problems are among the other health issues women bring to their attention, they said.

And because they are women who often know first-hand about these problems — PMS, for instance — female physicians can sometimes relate more easily to their patients than a male doctor.

Dr. Wills, 44, a newlywed and dedicated pet owner, and Dr. McDonald said keeping an active life outside their clinic relieves much of the stress associated with medicine.

"It helps keep you sane," Dr. McDonald said. She has juggled career and family since her first year in college, so balancing her profession with home life has been a way of life for her. Obstetrics has required her to be on call at unusual times, so Dr. McDonald has employed a nanny to ease her load. ■

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Karen McNiece

MEDICAL STUDENT

Senior at UAMS Seeks Survival Skills for Life

By Judith M. Gallman

Student Looks for Good Medicine Outside Classrooms, Hospital

It's tough being a medical student. Just ask Karen McNiece, who sometimes introduces herself to patients of a "certain generation" as "student Dr. McNiece." That's so the patients will know McNiece is studying to become a doctor, not a nurse.

McNiece, 24, is a fourth-year medical student at the University of Arkansas for Medical Sciences, and she plans to pursue a career in pediatrics.

While female medical students of yesterday may have been steered toward pediatrics, family medicine and psychiatry as their male counterparts were encouraged to become surgeons and orthopedists, McNiece arrived at her decision to practice pediatrics on her own, though she briefly considered psychiatry.

She said she chose pediatrics because she likes children and science. More specifically, McNiece likes treating the diseases that are common among children.

McNiece graduated cum laude in biology from Hendrix College in Conway, her hometown. Her father is an orthodontist, and her mother is a speech pathologist. McNiece has a brother who is a student at Hendrix.

McNiece has wanted to become a doctor since she was in junior high school, and she said she has been committed to pediatrics for nearly as long.

As with many medical students, McNiece found her first year of medical school the most difficult, simply because there was too much content to absorb in a limited amount of time. She was all books, but she began to learn to take some time out for herself in her second year of medical school by joining the choir at Pulaski Heights United Methodist Church. She also has been a youth choir counselor there.

She also developed an interest in the Arkansas Medical Society/American Medical Association-Medical Student Section.

During her sophomore year of medical school, McNiece was elected an alternate delegate to the organization and served as a delegate. The following year, she was elected president, and she now serves as the medical student councilor for the AMS Council. What McNiece discovered through her involvement saddened her: Students and residents were not involved in the student organization.

McNiece believed students were missing out on a valuable



Photo: Spencer Tirey

resource, so she tried to whip up enthusiasm. Eventually she pushed for student membership of AMS committees because she believed that students and residents could learn immensely from AMS members.

It does a medical student little good, McNiece decided, to master medicine if he knows nothing about delivery, and that's something students don't learn in the classroom. They can graduate without being able to balance a checkbook or understand compliance issues.

"Our medical system is broken," McNiece said. "We have to understand it to fix it. The more who try to understand it, the better the chances for success." And the answer should not come from a nonphysician, she said. ■

Fayetteville Physician First in Her Field

By Patricia May

Helping HIV Patients, Teaching Reward Innovative Doctor

Dr. Linda McGhee often has been first in her field — she was the first woman to serve on the Arkansas State Medical Board, the first woman president of the Arkansas Academy of Family Physicians and the first physician in the state to establish an HIV clinic.

But to this dynamic doctor, it's obviously the latter accomplishment that means the most — not because she was first, but because the need is so great.

"I would do it all over again," Dr. McGhee said of her career. The Fayetteville doctor is board certified in pediatric and family practice.

Dr. McGhee is a Little Rock native who lives with her husband, Garry, and daughter, Gabrielle. The couple's son, Quentin, is grown and lives in Little Rock.

Dr. McGhee is medical director of the Washington County HIV Clinic. She's also a member of the University of Arkansas for Medical Sciences faculty, which means she works with residents doing three-year rotations through the Area Health Education Center in Fayetteville. During her tenure, 99 residents have graduated.

Because Dr. McGhee's specialty is family practice, she also has an active caseload, and she helps with other types of education, too.

An Interest Sparked

As a child, Dr. McGhee's career dream didn't include medicine. Her goal was to be a geologist. That desire didn't last through high school, although Dr. McGhee still loves rocks and anything to do with nature.

By the time Dr. McGhee reached college, she was ready to pursue a nursing program, primarily



Photo: Bill Bowden

because it was a relatively short curriculum. She quickly learned of various scholarship and loan programs that were available to medical students and she became a premed major while a freshman at what's now the University of Arkansas at Little Rock.

Dr. McGhee said she'd encountered no special problems as a woman in medicine. But then, she didn't expect to. She's from a family of physicians and recalls as a child being around an aunt and her friends, all of whom were doctors.

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pediatrics, Dr. McGhee chose pediatrics. She believed that a physician who was competent with infants had a good grounding for treating other patients. When the family practice specialty subsequently became available, Dr. McGhee undertook that education program. Since completing her residency, she's been a UAMS faculty member.

"A teaching doctor is wonderful because it gives you an excuse to keep learning," she said.

Two Roles

The AHEC clinic on the east side of Fayetteville is a pleasant environment. On a recent day, there was vegetarian lasagna for staff members, who line up to enjoy brief lunch breaks. Dr. McGhee said there were similar luncheons as often as three times a week, and she admitted it was a fun place to be.

"It's a privilege to be a doctor and a double privilege to work with young doctors," she said. "You learn a lot working with young people."

She insists her natural pose at the AHEC clinic is with a pen in one hand, making chart notations, and holding a phone to her ear with the other.

But this is only one of her clinics. There's also the county HIV clinic.

It was as much chance as anything that led Dr. McGhee to her work with HIV patients.

"HIV came to me when a young [HIV-positive] man came in to our clinic," she said. "He was the first patient in Northwest Arkansas. He had it; he knew he had it and I had to quickly then learn about it. Nobody in the state really had any expertise [in that area], so I learned by telephone by talking to the folks in San Francisco."

Dr. McGhee declined to say what year that was. She laughed and said, "I

don't want to see it in black and white" — but it's fair to say her caseload of HIV-positive patients grew considerably after that.

As she explained, "After you get the first patient, when somebody gets another case, they say, 'Well, so-and-so's had one.' . . . By about five cases, you're considered to be competent; 50 cases is an expert."

By 1991, it was clear there was a need for more help. Michael DeBoer, then

president of Washington Regional Medical Center in Fayetteville, met with Charles Johnson, who was then county judge, Dr. McGhee says. Together they came up with the idea of an HIV clinic, which is in its sixth year.

HIV Help

The clinic is supported by the four major hospitals in Northwest Arkansas — Washington Regional, Northwest Medical Center in Springdale, St. Mary's in Rogers and Bates Medical Center in Bentonville. It's also supported

by the county with space in the new Washington County Health Department.

The clinic offers treatment and education, and its staff includes a full-time educator. That position has been fully funded by the Levi-Strauss Foundation, even after the closing last year of a Levi's plant in Fayetteville, Dr. McGhee says.

"We have an active caseload of about 200 patients. We're doing pretty well here in Northwest Arkansas. The number of cases continues to grow but not at the accelerated rate of the early 1990s."

Despite her heavy workload, Dr. McGhee enjoys it.

"If you love your work, you don't feel like you're [at work]," she said. ■

**"It's a privilege to
be a doctor and a
double privilege to
work with young
doctors. You learn a
lot working with
young people."
— Dr. Linda McGhee**

Determination Drives Dr. Nichols

By Judith M. Gallman

Departure From Public Arena Allows Time for Self, Family

Dr. Sandra Nichols knows what it means to start out life with a disadvantage: She's a product of the projects.

But Dr. Nichols, 41, has never let that stand in her way. In fact, she uses her background to inspire others, telling them, "You, too, can do this. Look at me; I'm a kid from the projects."

That was the message she once delivered to a graduating class of 25 in the tiny burg of Holly Grove, she said.

Today, Dr. Nichols, a family practice physician, is medical director of United Healthcare Corp. of Arkansas, a large health maintenance organization. Before that she was the state's chief medical director from 1994-98 as director of the Arkansas Department of Health. She was appointed to lead the agency at 36 and was the second black woman named as the health department director.

In a recent interview, Dr. Nichols acknowledged that she wondered whether her race or sex influenced her selection for the high-profile job, but she decided the answer didn't matter. What did matter, she said, was how she as an individual did the job.

So she worked hard, learning the department inside out and reading every letter that bore her signature, she said. She spent long hours developing health policy and was the state's chief health representative in emergencies, from failed municipal sewer systems to outbreaks of hepatitis or influenza. She took her role seriously and personally.

Dr. Nichols took on leadership roles in national organizations at the same time her cabinet-level position required her presence on state committees, including one overseeing disposition of stockpiled nuclear weapons at the Pine Bluff Arsenal.

"There were lots of demands," she said, adding she liked the administrative aspects of her job. "I was very busy, but I missed the medicine part."

As medical director at United Healthcare, a



Photo: Spencer Tirey

private company, Dr. Nichols combines her medical knowledge with administrative strengths and is responsible for medical benefit interpretations. She reviews cases and often interviews physicians in making her determinations.

The job is less stressful than being in the public arena, she said, and gives her more time to be a mother and wife. She has a 9-year-old daughter, Marquise. Dr. Nichols finds she now has time for herself, an often overlooked area for most women. She is married to Ronnie A. Nichols, a consultant.

School Days

Dr. Nichols grew up in Little Rock, graduating from Little Rock

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Parkview in 1976 as student council president, an early lesson in how determination pays off.

Dr. Nichols attended Columbia College in Columbia, Mo., where she earned a degree in chemistry. She obtained a master's degree in biology at Tennessee State University in Nashville, Tenn., and then started her medical career at the University of Arkansas for Medical Sciences, where she was chief resident and the recipient of a fellowship in occupational and environmental medicine.

A detail-oriented student who wanted to understand medicine very well, Dr. Nichols said her school and professional careers progressed evenly because she is a "stick-to-it person" and "dogmatic."

Dr. Nichols served as medical educator of the UAMS Delta Health Clinic, which prepared her for a move to interim medical director of the Mid Delta Health Clinic in Holly Grove. Her husband was then working as director of the Delta Cultural Center in Helena.

The Delta, Dr. Nichols said, reminded her of her East End roots and she felt compelled to give back to her community, also a reason she signed on for the health department job.

Dr. Nichols chalks up her personal and professional successes to determination, her mother and faith. She was one of six children who was raised by a single mother, Ether Bruce Lipkins.

"She had six children and two jobs and found the time to study," Dr. Nichols said.

Dr. Nichols said her mother's dedication instilled in her a drive to accomplish even more.

Dr. Nichols said she is pleased that young women are being trained now to be more flexible and noted the impact of the Women's National Basketball Association, soccer and other sports on girls' self-esteem.

"Girls are not as limited," she said. "Fathers are teaching girls to be very independent."

Dr. Nichols said she has experienced racial and sexual discrimination, but she has overcome such prejudices by refusing to allow her detractors to limit her capabilities.

"I will set that glass ceiling," Dr. Nichols said. "I have had a fabulous career. It's a blessing." ■

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Record Wins, Doctor Loses

J. KELLEY AVERY, MD

Case Study

A 34-year-old woman had an elective termination of her second pregnancy a year before this visit to her obstetrician. Following the abortion, she was given Demulen 1/28 to take for contraception. She visited her physician for her annual checkup two months later, and his record revealed essentially normal findings with specific reference to the documentation, "Breast exam: Without mass or discharge, some fibrocystic changes noted. Pap smear negative."

A year later, the patient presented herself to her doctor for the annual examination and, again, the record stated, "Breast exam: No mass or discharge." It was at this visit that the patient would later say that she reported what she thought was a lump in her left breast. Due to oligomenorrhea, the Demulen was changed to 1/50 for two months after which she was to resume the regular strength of 1/28. Again the Pap smear was reported as negative.

Three months after this visit, she referred herself to a mammography service because of continuing concerns about the lump she thought she felt in her left breast. The mammography report stated that there was a cluster of calcifications at the 12-o'clock position in the left breast, which the radiologist thought were benign and a repeat was suggested in six months. What was notable about this visit to the mammography clinic was that the sign-in form included the family history that an aunt and a cousin had died of breast

cancer. A week later the mammography report was given to the patient over the telephone by the office staff of her obstetrician.

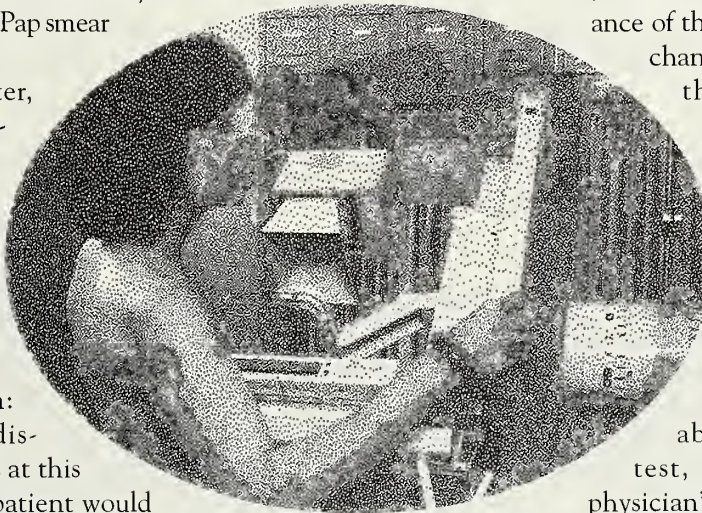
The patient returned for her repeat mammogram six months later as suggested by the radiologist. Again, on the sign-in form, the family history of breast cancer in an aunt and a cousin was recorded. The mammogram again showed the calcifications previously described, but stated that the appearance of the breast was unchanged and, again,

the radiologist thought that a repeat in six months was indicated. The word "benign" was not used in this report.

"Worried" about this latest test, she called her physician's office, and because the doctor was not in the office, the office personnel again tried to be reassuring about the report. The patient was not satisfied, and she was referred by the office staff to the general surgeon used by this office for a consultation. It was the same office employee who gave the patient the mammography report on both occasions, and the same person referred her to the surgeon.

The surgeon's examination of the breast was recorded in his record, "Medical history positive for cancer, maternal aunt and maternal cousin died from breast cancer." The surgeon's examination found, "dimpling and a 3-cm mass." The location of the mass corresponded to the area of the calcifications reported by the mammographer.

What was notable about this visit to the mammography clinic was that the sign-in form included the family history that an aunt and a cousin had died of breast cancer.



A biopsy was done, and the diagnosis of cancer was confirmed. A week later a modified radical mastectomy was done, and two out of 13 nodes were found positive for malignancy.

The patient was treated with the routine radiation and chemotherapy protocol, and at three years after the operation she is clinically free of disease. A lawsuit was filed charging the obstetrician with failure to do a proper breast examination, failure to refer for mammography and failure to refer to a surgeon. Three years after the surgery, with the patient apparently healthy and free of disease, the case was settled for a large sum of money.

Loss Prevention Comments

This case demonstrated again that in a swearing contest between the patient and the physician as to what was said or done in the encounter between the two, the physician is at a tremendous disadvantage unless the contemporaneous record of that encounter describes it in some detail. Here the patient said that she told the doctor of the lump she found in her breast. There was no record of the history having been taken by her doctor when she came in for her annual examination. Supporting evidence for the lack of history was the sign-in card in the mammography clinic which, on both occasions, recorded the positive family history for breast cancer. Supporting the contention that the defendant physician had not done a careful breast examination was the consulting surgeon's finding of "dimpling" and a "3-cm mass" just nine months after the examination in question.

It is reasonable to conclude that the patient was concerned about her suspicions of a lump in her left breast because she referred herself to the mammography facility. She did not call for an appointment with her doctor before or after the X-ray examinations. The plaintiff attorney's contention was that she was already dis-

This case demonstrated again that in a swearing contest between the patient and the physician as to what was said or done in the encounter between the two, the physician is at a tremendous disadvantage unless the contemporaneous record of that encounter describes it in some detail.

satisfied with her obstetrician's examinations and his failure to examine her complaints.

Things would have been a lot different both clinically and legally if she had been called in and reexamined by her obstetrician after the first mammogram. At that visit he could have expressed his own concern for her apprehension, and on the basis of his examination either referred her to the consulting surgeon for his opinion or followed her more closely himself. There is no substitute for the empathy expressed by the attention of the physician to the concerns of the patient in a situation of this kind.

There were very credible nationally known experts in pathology, oncology and surgery who were ready to support this physician as to the facts that had the lesion been found at the initial examination, it would have made absolutely no difference in the prognosis. They further expressed the opinion that given the postoperative treatment by radiation and chemotherapy and the fact that three years later she was clinically free of disease, her chances of dying of her disease was probably 10% or less.

However, the plaintiff attorney can buy the kind of experts he or she needs in cases like this and others. Plaintiff attorneys keep careful files of the experts who can and will give a contrary opinion to the testimony of defense experts. It is from this database that their experts are chosen. It seems not to make much difference that though these experts many times have academic affiliations from prestigious institutions, they have little

hands-on clinical practice and make a career out of testifying for the plaintiff. The distinction between the credible and the "for hire" experts is left to a lay jury, and in this case that was a gamble the defendant physician was not willing to take.

The lessons to learn are two. The first is to listen to the patient's story and to deal with concerns expressed in words or behavior. This patient expressed her anxiety about her condition by going to the mammographer without telling her physician. Once he knew that, he would have been better served by calling her in for further consultation. The second lesson is to document carefully the history and physical examination. Critical elements of the history did not appear in the physician's record but first appear in the radiologist's sign-in card. More attention to the documentation of the record and to the expressed concerns of the patient would probably have prevented this lawsuit. After all, that is what we are trained to do!■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the December 1998 issue of Tennessee Medicine. It is reprinted with permission.



Clockwise (L-R): Bill Smith, Keith McCullough, Stan Russ, Stephen Chaffin and Jim Strawn

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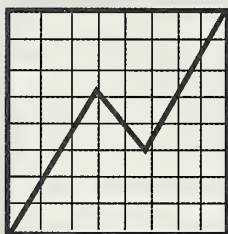
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Tickborne Diseases in Arkansas, 1994-1998

Tickborne diseases continue to pose significant health problems for residents and visitors of Arkansas. While some cases of illness are reported as Lyme disease, more cases of Rocky Mountain Spotted Fever (RMSF), ehrlichiosis and tularemia are reported.

Four hundred and four cases of these diseases (Fig. 1) were reported by Arkansas physicians during 1994-1998, and an unknown number of cases were undoubtedly avoided by prompt appropriate treatment. Seven deaths were recorded among the cases: three from RMSF and four associated with ehrlichiosis.

Lyme disease has been the most frequently reported tickborne disease in the United States in recent years. It is still found predominantly in limited areas of high incidence, and the diagnosis is problematic outside those areas. In Arkansas, the causative organism has not been demonstrated in ticks, which are potential vectors. Nor have cases been confirmed by the two-step serological testing recommended by the Centers for Disease Control and Prevention.

The CDC states that false-positive tests are probable in areas of low Lyme disease incidence, such as Arkansas, and diagnosis requires confirmation of EIA screening tests by Western blot testing. If desired, the Arkansas Department of Health will provide testing for Lyme disease and other tickborne diseases at no charge. Preferably, both acute and convalescent serum samples should be submitted with a request for a tickborne disease panel. Specimens may be submitted separately, but since no single titer is diagnostic by itself, convalescent serum testing should be done to confirm a clinical impression.

Tickborne diseases are likely to occur in residents in any county in the state, as tick exposure may occur at a person's place of residence or occupation, as well as during recreational activities.

The probability of infection varies seasonally, with fewer infections reported during the winter months. Tick populations increase in number during spring months, and more infections occur in June than in any other month (Fig. 2).

Children in the 0-14 year age group have the greatest probability of having an infection reported (Fig. 3). This probably reflects their greater risk of exposure through rec-

**Reported Tickborne Disease Cases in Arkansas
1994-1998**

	1994	1995	1996	1997	1998
RMSF	18	31	22	33	24
Tularemia	23	22	24	24	26
Ehrlichiosis	12	14	7	22	13
Lyme Disease	15	12	27	27	8

Figure 1

**Reported Tickborne Disease Cases in Arkansas
1994-1998 by Month of Onset**



Figure 2

**Reported Tickborne Disease Cases in Arkansas
1994-1998 by Age Group**

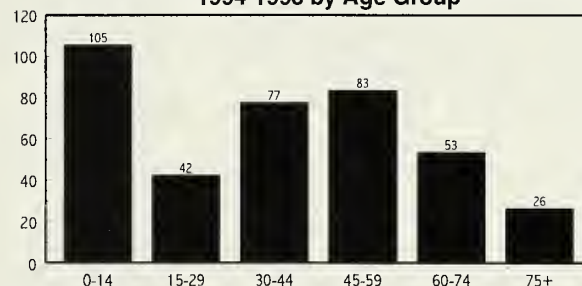


Figure 3

reation or through contacts with their pets. Sixty-nine percent of cases are males, reflecting a greater risk of exposure through occupational or recreational activities. ■

For more information concerning tickborne diseases in Arkansas, call the ADH Division of Epidemiology at (501) 661-2893 during normal business hours.

Study Classifies Low Body Mass Index as Risk Factor for Osteoporotic Fracture Among Older U.S. Women

LORI W. TURNER, PH.D., R.D.
OLIVIA KENDRICK, DR.P.H., R.D.
BLAKE A. PERRY, M.S.

Fractures from osteoporosis are a major public health problem in the western world.¹ Osteoporosis is a crippling condition that results in premature mortality and significant morbidity, which may be manifested in the form of fractures, bone deformity and chronic pain.²

Osteoporosis is one of the most prevalent diseases of aging, affecting more than 25 million people in the United States, 80 percent of whom are women.³ It is responsible for approximately 250,000 hip fractures a year and an annual total of 1.5 million fractures in the United States.⁴ Among women in 1991, annual incidences of osteoporotic fractures were more than 1 million.⁵ When a woman enters her fifth decade of life, she has a 40% chance of experiencing an osteoporotic fracture sometime during her remaining lifetime.⁶

The economic cost of osteoporotic fracture is estimated to be \$13.8 billion annually of which \$10.3 billion is for treatment of white women.⁷ As the population ages, and medical costs escalate, estimates are staggering. Considering the growth of this aging group, the annual number of hip fractures could triple by the year 2040. One conservative estimate states that the cost of hip fractures alone will escalate to approximately \$240 billion by the year 2040.⁸

Women who are underweight are at risk for osteoporosis and associated fractures.



Research indicates that body weight and total body fatness are significant and consistent predictors of bone density.⁹ The purpose of this study was to determine the significance of body mass index in the occurrence of osteoporotic fracture among a national sample of women 50 years and older. Implications for medical practice also were described.

Methods

Subjects included in this study were participants in the Third National Health and Nutrition Examination Survey (NHANES III), Phase 1. Data for NHANES III were collected from 1988 to 1994. This large-scale national health survey was conducted by the National Center for Health Statistics. Household interviews included demographic, socioeconomic, dietary and health history items. For purposes of this study, only women 50 years and older were studied because osteoporosis had been studied most extensively in older women because

these women were considered at risk for osteoporotic fracture.⁶ The sample for this study included 2,336 women 50 years and older.

The nine predictor variables that were examined in this study were frequently cited risk factors for osteoporotic fracture.¹ They included age, race, biological mothers' osteoporosis status, biological mothers' hip fracture status, body mass index (BMI), physical activity, smoking status, alcohol use and dairy product intake.

Age and race were based on self-reported information. Age was defined as age in months or years at the time of the household interview. This value was calculated using date of interview and date of birth. Subjects were classified into age groups of 50-64 years and 65 years and older. Women 65 years and older have been recognized as a high-risk group for osteoporotic fractures.⁸ Regarding race, subjects were classified as non-Hispanic white, non-Hispanic black, Hispanic

American and other.

The influence of heredity was determined by self-reported information obtained from two questionnaire items: "Was your biological mother ever told by a doctor that she has osteoporosis, sometimes called thin or brittle bones?" and "Did your biological mother ever fracture her hip?" Subjects were classified according to their responses of "yes," "no" or "I don't know."

To examine the effects of body size, body mass index (BMI) values were calculated from height and weight information. Participants were grouped into four BMI categories. Subjects were classified as underweight (BMI less than 20), acceptable weight (BMI between 20 and 25), overweight (BMI between 25.1 and 30) and severely overweight and obese (BMI greater than 30).

Physical activity information was obtained from responses to the following items: "In the past month, how often did you: walk a mile or more at a time without stopping; jog or run; ride a bicycle or an exercise bicycle; swim; do aerobics or aerobic dancing; do other dancing; do calisthenics or exercises; do gardening or yard work; lift weights; do other exercises, sports or physically active hobbies not mentioned?" Data from each of these responses were summarized to yield a total frequency of physical activity variable. Physical activity was defined in terms of frequency per week.

For general fitness, 20 minutes of exercise three times a week is recommended, however, specific guidelines do not exist for bone health.³ Several studies on bone density and exercise suggest exercise frequencies of three times a week while some evidence suggests more moderate activity of two times a week may be beneficial. Therefore, this study examined both activity levels.

Two analyses were conducted to determine if differences occur at activity levels of three times a week or more and levels of two times a week or more. The first physical activity analysis classified participants who reported that they performed any or a combination of the activities on average of three times per week as physi-

Table 1: (N=2,336)

Prevalence of Risk Factors and Osteoporosis-Related Outcomes

Characteristic	Frequency of Occurrence	Proportion of Sample
Age in years		
50-64	867	37%
>64	1469	63%
Race		
White	1373	59%
Black	506	21%
Hispanic	410	18%
Other	47	2%
Body mass index		
<20 (underweight)	399	17%
20-25 (normal weight)	966	41%
25.1-30 (overweight)	556	24%
>30 (severely overweight)	415	18%
Physical activity		
<2 times per week	1572	67%
≥2 times per week	764	33%
≥3 times per week	586	25%
Cigarette use		
Current smoker	398	17%
Former smoker	547	23%
Non-smoker	1391	60%
Alcohol use		
≥1 drink per day	81	4%
<1 drink per day	2255	96%
Dairy Product Use		
≥2 servings per day	574	25%
<2 servings per day	1762	75%
Osteoporosis Outcomes		
Diagnosis	179	8%
Hip fracture	180	8%
Wrist fracture	44	2%
Spinal fracture	8	1%

cally active and they were compared with subjects who exercise less than three times a week. The second activity analysis classified participants who exercised two or more times a week versus those who were active less often than twice a week.

Smoking information was obtained from responses to the following items: "Have you ever smoked at least 100 cigarettes during your entire life?" and "Do you smoke cigarettes now?" Subjects who reported they have smoked at least 100 cigarettes in their lifetime and that they are currently smoking were classified as smokers. Participants who reported they had smoked at least 100 cigarettes in their lifetime but were not currently smoking

were classified as former smokers. Subjects who stated that they had never smoked more than 100 cigarettes during their lifetimes were considered nonsmokers.

Alcohol use was measured from food frequency information. Subjects were asked, "How many times in the past month have you consumed beer, wine or hard liquor?" The dietary guidelines for Americans recommend that alcohol consumption be limited to the equivalent of less than 1 ounce of pure alcohol in a single day.¹⁰ Rationale for alcohol analysis was based on this recommendation and definition of moderation. Subjects were grouped according to reported consumption of one or more times a day (moderation or greater) versus less than one time a day.

Dairy product intake was selected to obtain information regarding calcium intake. Data from food frequency information were analyzed. Food frequency information is useful as it helps pinpoint food groups, and therefore nutrients that may be deficient in the diet. Dairy consumption may assist in determining whether calcium may be lacking in the diet. Subjects were asked how often they consumed milk, yogurt, cheese and ice cream. Responses to these questions were summarized to give a total number of dairy products consumed per day.

National health objectives recommend that people 25 years and older consume two or more servings of calcium-rich foods daily.⁸ Therefore, subjects who reported they consumed these products two or more times a day were compared with those who consume dairy products less than two times a day.

The outcome variable, osteoporotic fracture status, was measured by self-reported information obtained from the following items: "Has a doctor ever told you that you had broken or fractured your hip, wrist or spine?" and "Was that fracture a result of a fall from standing height or less, harder fall or severe trauma?" Women who responded "yes" to a fracture question and "yes" to the fracture being a result of a fall from standing height or less were classified as positive for osteoporotic fracture status.

To determine the significance of body mass index and other risk factors in the occurrence of fracture, stepwise logistic regression procedure was used. Statistical tests were performed using Statistical Analysis System (SAS) programs. SAS programs, widely used in social science research, are commonly used for multivariate analyses.

Results

The sample consisted of 2,336 women 50 years and older. The mean age of the women in this study was 68.8 years (SD=11.5, range 50-100). Thirty-eight percent (867) of the women were 50-64 years while 63% (1,469) were 65 years or older. Fifty-nine percent (1,373) were white, 22% (506) were black, 18% (410) were Hispanic American and 2% (47) were from other ethnicities. Oversampling of older and minority populations, a unique feature of NHANES III, is evident in these frequencies. Table 1 includes a description of the frequencies of risk factors and osteoporosis outcomes.

Table 2 displays results of logistic regression analyses and the quantitative predictive model generated. Results indicated that race, age, BMI and inactivity were significant risk factors. Analysis of race was conducted using white as the reference; results indicated that being black is a significant protective factor (O.R.=0.186, C.I.=0.100, 0.349) as well as being Hispanic (O.R.=0.477, C.I.=0.295, 0.772). Being 65 years of age or older was a significant risk (O.R.= 5.390, C.I.= 3.273, 8.878). Being underweight (O.R.=1.427, 1.000, 2.037) and inactive (O.R.=1.838, C.I.=1.293, 2.613) also were significant risk factors. Body mass index was independently significant when controlling for age, race and inactivity. Factors that were not significant included: mothers' osteoporosis status, mothers' hip fracture status, smoking status, alcohol use and dairy product intake.

Black women were 19% less likely to

suffer a fracture than white women. Hispanic women had 48% fewer odds of experiencing a fracture than white women. Women 65 years or older were 4.39 times more likely than women 50-64 years to suffer an osteoporotic fracture. Women with low BMI were 43% more likely to experience fractures than women in BMI categories of normal, overweight or severely overweight. Inactive women had 84% greater odds of suffering fracture than females who were active two or more times per week.

Discussion

Research indicated that body weight and total body fatness were significant and consistent predictors of bone density. Studies also indicate that low BMI was a significant and inde-

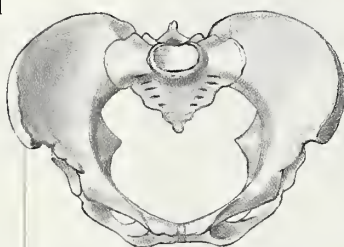


Table 2: (N=2,336)

Significant Correlates for Osteoporotic Fracture

Variable	P Value	Odds Ratio	Confidence Interval
Black	0.0001	0.186	0.100, 0.349
Hispanic	0.0026	0.477	0.295, 0.772
Age (\geq 65 years)	0.0001	6.390	3.273, 8.878
BMI (low)	0.0500	1.427	1.000, 2.037
Inactivity (< 2 times/wk)	0.0007	1.838	1.293, 2.613

Nonsignificant variables: mothers' osteoporosis status, mothers' hip fracture status, smoking status, alcohol use, dairy product intake.

pendent risk factor for osteoporotic fractures and fall severity.

The present study confirmed prior research, supporting the idea that underweight women are at high risk for osteoporotic fracture. In the present study, low BMI was a significant and independent risk factor.

Previous research indicated that obesity may have a protective effect against osteoporosis possibly due to higher blood levels of estrogen in obese postmenopausal women or due to the mechanical effects of excess weight on bones. Results from the present study confirmed the protective effect of obesity when compared to underweight subjects. The present study indicated that overweight and severely overweight women were at reduced

risk for osteoporotic fracture when compared to underweight women.

Logistic regression analyses in the present study were conducted with normal BMI as the reference group. Results indicated no significant differences between the normal weight group, the overweight group and the severely overweight group. These results suggested that being overweight (and even severely overweight) was only preferable to being underweight.

Implications

Results obtained from the present study have implications for medical practice. Designing screening procedures that target strong independent risk factors is a primary goal in effectively preventing and treating people with conditions and diseases. Low BMI was classified as a strong, independent risk factor for fracture. This indicated the need for women who are underweight to be screening for osteoporosis.

In addition, this has implications for prevention and treatment. Prevention and treatment guidelines should promote achievement and maintenance of healthy body weights. A balanced diet that includes adequate calories to promote weight gain will include two or more servings of dairy foods. While this study showed no significant benefit of dairy product intake, dairy foods are an important part of a balanced diet and can be an important component of this strategy.

Findings from the present study and from previous research also point to the need for prevention interventions that target women earlier in their lives. Young women should be informed about the risks of osteoporotic fractures. Maintenance of healthy body weights, nutrition education, smoking cessation and physical activity interventions were suggested in younger years for osteoporosis and fracture prevention.

This is a challenging task in a society that promotes an excessively thin body image for women. Many women

perceive the need to adhere to unrealistic ideals for body weight and devalue themselves if they do not conform to them. Even many beautiful, normal-weight female adolescents perceive that they are too fat. In one study, an alarming two-thirds of adolescent girls were dissatisfied with their body weight and shape. As a result, young women, in their pursuit of attractiveness, often engage in behaviors, including eating disorders, which promote excessive weight loss and predispose themselves to a host of health problems, including osteoporosis.

Health professionals can be alert to these potential problems and attempt to identify them early in susceptible young women. Disordered eating patterns are extraordinarily common among young, white, middle- and upper-class girls. Helping young women discard society's unrealistic, unhealthy images is part of prevention.

Results of the present study point to the need for educational materials regarding osteoporosis to include the strong ef-

fect of BMI on the development of this disease. Existing counseling literature focuses on calcium intake and minimizes the importance of body weight. Through active intervention health care professionals can work together to reduce the impact of osteoporosis. ■

References

1. Lindsay R. The burden of osteoporosis: cost. *Am J Med.* 1995;98(suppl):9-11.
2. Keene G S, Parker MJ, Pryor GA. Mortality and morbidity after hip fractures. *Brit Med J.* 1993;307:1248-1250.
3. McBean LD, Forgac T, Finn, SC. Osteoporosis: visions for care and prevention—a conference report. *J Am Diet Assoc.* 1994;94:668-671.
4. Dempster DW, Lindsay R. Pathogenesis of osteoporosis. *Lancet.* 1993;341:797-801.
5. National Osteoporosis Foundation. A status report on osteoporosis: the challenge to midlife and older women. Washington, DC; 1995.
6. Melton LJ. Perspective: how many women have osteoporosis. *J Bone Min Res.* 1992;7:1005-1010.

7. Ray NF, Chan JK, Thamer M, Melton LJ. Medical expenditures for the treatment of osteoporotic fractures in the United States in 1995: report from the National Osteoporosis Foundation. *J Bone Min Res.* 1997;12:24-35.

8. Cummings SR, Rubin SM, Black D. The future of hip fractures in the United States. *Clin Orthopedics.* 1990;252:163-166.

9. Edelstein SL, Barrett-Connor E. Relation between body size and bone mineral density in elderly men and women. *Am J Epid.* 1993;138:160-169.

10. Committee on Diet and Health Food and Nutrition Board. Diet and health: Implications for reducing chronic disease risk (pp. 99-135). Washington, D.C.: National Academy Press; 1989.

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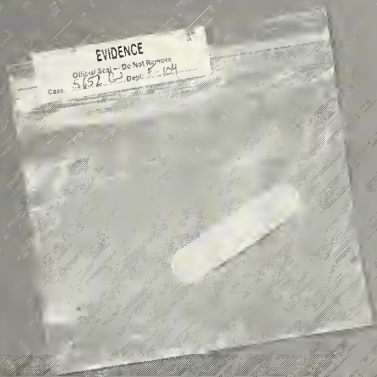


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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CARDIOLOGY



Mechanical Complication of a Myocardial Infarction: Ventricular Septal Rupture

SAYYADUL SIDDIQUI, MD
MARK ST. PIERRE, MD
J. DAVID TALLEY, MD



Figure Legend 1. Right anterior oblique projection of the cardiac silhouette. The injection is in the left ventricular cavity. The darker area (large arrow) indicates that the right ventricle also is opacified due to transseptal flow of the radiographic contrast from the left to the right ventricle.

Rupture of the inter ventricular septum (VSR) is a serious mechanical complication of myocardial infarction and occurs in 1-3% of all acute myocardial infarctions.¹ If treated conservatively, mortality is 50% in one week and approaches 90% at two months.² VSR accounts for approximately 5% of peri-infarction deaths.³ We recently cared for a patient who sustained this mechanical complication after a myocardial infarction and reviewed the diagnosis and treatment of this condition.

Patient Presentation

Hospital Admission #1

A 65-year-old man was admitted to the hospital with chest pain consistent with myocardial ischemia and was found to have enzymatic evidence of a non-Q wave myocardial infarction. He was treated with aspirin, heparin and beta-blocker therapy. His past medical history was significant for systemic arterial hypertension, hypercholesterolemia, coronary artery disease and coronary artery bypass graft surgery in 1989 (see complete problem list, Table 1). Cardiac catheterization revealed severe three-vessel native coronary ar-

tery disease with total occlusion at mid-right coronary artery. There were patent vein grafts to the left anterior descending and obtuse marginal arteries. Left ventriculography showed inferior basilar akinesis and the calculated left ventricular ejection fraction was 55%. He remained free of chest pain and was discharged to home five days later on medical regimen consisting of an aspirin, beta-blocker, angiotensin converting enzyme inhibitor and a lipid lowering agent.

Hospital Admission #2

Two days after discharge, he was readmitted with recurrent chest pain and shortness of air. There was marked jugular venous distention and inspiratory crackles in both lung bases. A new grade III/IV harsh holosystolic murmur was heard at left lower sternal border. Admission chest X-ray showed pulmonary edema.

A bedside echocardiography found a color-flow defect high in the inferior muscular portion of the interventricular septum with an estimated pulmonary to systemic blood flow ratio of 2:1. Left ventricular systolic function was normal.

The patient was hemodynamically stable and underwent an attempted surgical repair of the defect. He is now is at home recuperating.

Discussion

Pathophysiology

In 1957, Cooley reported the first operative repair of VSR, prior to which was nearly always fatal.⁴ VSR may occur in patients with limited coronary artery disease.⁵ In a necropsy series reported by Mann and Roberts, patients who sustained a VSR after a myocardial infarction had less severe coronary artery disease than those who died after a myocardial infarction without a VSR.⁶ Of note, 25% of patients who died after VSR were found to have only one vessel with greater than 75% luminal narrowing. Angiographic studies indicate that most patients with VSR have inadequate collateral blood flow. Also, a vast majority of patients diagnosed with post-myocardial infarction VSR have no prior history of myocardial infarction.^{6,7,8,9,10} Together, these findings suggest myocar-

Table 1- Complete Cardiac Diagnosis

Etiology: Atherosclerosis, Systemic Arterial Hypertension

Anatomy: *Cardiac Catheterization:* 90% proximal LAD artery obstruction; 90% proximal left circumflex artery obstruction. RCA branches in the mid-portion and the superior branch is totally occluded. LIMA to LAD and saphenous vein graft to obtuse marginal artery is patent.
Electrocardiogram: Ventricular Septal Defect in high inferior muscular portion of the septum. Normal left ventricular wall thickness. Normal morphology of the mitral valve.

Physiology: *Electrocardiogram:* Normal sinus rhythm, rightward axis, first degree A-V block and anteroseptal infarct.
Electrocardiogram: Normal left ventricular systolic function, estimated LVEF >55%. Infero-septal dyskinesia. Pulmonary to Systemic blood flow ratio 2:1.

Functional: Class IV

Objective: Severely Compromised

dial infarction in an area poorly supplied with collateral blood flow predisposes to VSR.

VSR most commonly occurs during the first week after myocardial infarction.⁷ Typically, patients present with acute onset of cardiogenic shock. A new holosystolic murmur is the most common physical finding. Approximately one half of the patients also will have a thrill over the precordium. Venous pressure is elevated. Chest radiography shows prominent vascularity, but frank pulmonary edema is infrequent. According to Mann, electrocardiographic localization of myocardial infarction has very good correlation with location of the VSR.⁶

Natural History

Without surgical intervention, 60% of patients develop rapid hemodynamic deterioration within a week resulting in death from cardiogenic shock. The remainder of patients remain in severe symptomatic heart failure, which progressively worsens, resulting in 90% mortality over two months with medical therapy alone.

Diagnosis

The differential diagnosis in a pa-

tient with a new onset systolic murmur after acute myocardial infarction include papillary muscle dysfunction or rupture, ventricular septal rupture, pericardial rub, tricuspid regurgitation and left ventricular outflow tract obstruction. After history and physical examination, echocardiography is the diagnostic method of choice in a patient who is post-myocardial infarction and has a systolic murmur. With the addition of Doppler color flow mapping, the sensitivity approaches 100%.¹¹

Echocardiography shows the location of the disrupted myocardium as well as the shunt direction with an estimation of pulmonary and systemic blood flow. Occasionally, transesophageal echocardiography may be necessary in a patient with inadequate transthoracic echo image. Right heart catheterization also is used to diagnose VSR. An increase in oxygen saturation between the right atrium and right ventricle is diagnostic.

Management

Conservative treatment of a post-myocardial infarction VSR carries a dismal prognosis and therefore definitive treatment must be surgical correction of the septal defect. The optimal timing of surgical correction of VSR is controver-

sial. The debate stems from the knowledge regarding myocardial healing after infarction as observed by Mallory in 1939.¹²

According to his observation, collagen fibers, which are responsible for mechanical strength in the scars, do not appear until 12 days after infarction and attain their highest density at two months. It was therefore postulated and practiced during the 1960s to wait for several weeks before surgical correction would be attempted. Alternative strategies to perform earlier surgical correction were undertaken by many surgical groups during the 1970s because many of the patients would either die or develop irreversible hemodynamic deterioration while waiting for repair.

Historically, the operative mortality is high in patients operated on early rather than late. However, multivariate analysis done by Gaudiani showed the time interval between occurrence of VSR and surgery in itself is not a significant factor for mortality and most likely represents the natural course of the disease.⁸ At present, there is no consensus regarding optimum timing for surgery.

The surgical correction involves approach to the ruptured septum through the infarcted myocardium, and the septal defect is repaired either by placing a prosthetic patch or direct plication. Infarctectomy also is performed when appropriate.¹³ Concurrent coronary artery bypass has not been shown to improve outcome but is done at the individual operator's preference. Medical therapy prior to surgical correction includes afterload reducing agents, diuretics and inotropic support if necessary. An intra-aortic balloon pump is frequently used in case of hemodynamic collapse.

The operative mortality between 1973 and 1987, comparing a total of 585 patients in 23 published surgical series, had an overall in-hospital mortality of 43%.⁹ According to 16 series published between 1987 to 1992, each with 30 or more patients, early surgical mortality is 10-67%.¹⁴ Actuarial survival among operative survivors is good; one recent study reporting actuarial survival

rate of 65% at seven years. Of these patients, 91% of this patient group remained in New York Heart Association functional class I-II.¹⁵

Several factors have been examined to determine their independent prognostic value for predicting outcome in surgical repair of VSR. Of those factors, presence of shock carries independent prognostic value. Nonsurvivors of VSR repair were characterized by a shorter time from post infarction VSR to operation, presence of inferior infarction, right ventricular dysfunction, lower right ventricular pressure, decrease in level of consciousness.⁹ Interestingly, left ventricular dysfunction was not found to be an indicator of short-term clinical outcome.¹⁴

Conclusion

Ventricular septal rupture is a serious mechanical complication of acute myocardial infarction requiring prompt recognition and surgical correction. A harsh systolic murmur and rapid hemodynamic deterioration herald it. It is more common in the first episode of myocardial infarction. Despite dramatic early clinical course and high operative mortality, survivors can be expected to have favorable long-term survival and functional recovery.

References

1. Dellborg M, Held P, Swedberg K, Vedin A. Rupture of the myocardium: occurrence and risk factors. *Brit H J* 1985;54:11-16.
2. Sanders RJ, Kern WH, Blount SG. Perforation of the interventricular septum complicating infarction. *Am Heart J* 1956;51:736-748.
3. Hutchins GM. Rupture of the interventricular septum complicating myocardial infarction: pathological analysis of 10 patients with clinically diagnosed perforations. *Am Heart J* 1979;97:165-173.
4. Cooley DA, Belmonte BA, Zeis LB, Schnur S. Surgical repair of ruptured interventricular septum following acute myocardial infarction. *Surgery* 1957;41:930-937.
5. Hill JD, Lary D, Kerth WJ, Gerbode F. Acquired ventricular septal defects. Evolution of an operation, surgical technique, and results. *J Thorac Cardiovasc Surg* 1975;70:440-450.
6. Mann JM, Roberts WC. Rupture of the left ventricular free wall during acute myocardial infarction: analysis of 138 necropsy patients and comparison with 50 necropsy patients with acute myocardial infarction without rupture. *Am J Cardiol* 1988;62A:847-859.
7. Radford MJ, Johnson RA, Daggett WM Jr, Fallon JT, Buckley MJ, Gold HK, Leinbach RC. Ventricular septal rupture: a review of clinical and physiologic features and an analysis of survival. *Circulation* 1981;64:545-553.
8. Gaudiani VA, Miller DG, Stinson EB, Oyer PE, Reitz BA, Moreno-Cabral RJ, Shumway NE. Postinfarction ventricular septal defect: an argument for early operation. *Surgery* 1981;89:48-55.
9. Cummings RG, Califf R, Jones RN, Reimer KA, Kong YH, Lowe JE. Correlates of survival in patients with postinfarction ventricular septal defect. *Ann Thorac Surg* 1989;47:824-830.
10. Keenan DJ, Monro JL, Ross JK, Mann JM, Conway N, Johnson AM. Acquired ventricular septal defect. *J Thorac Cardiovasc Surg* 1983;85:116-119.
11. Smyllie JH, Sutherland GR, Geuskens R, Dawkins K, Conway N, Roelandt JR. Doppler color flow mapping in the diagnosis of ventricular septal rupture and acute mitral regurgitation after myocardial infarction. *J Am Coll Cardiol* 1990;15:1449-1455.
12. Mallory GK, White PD, Salcedo-Salgar J. The speed of healing of myocardial infarction: a study of the pathologic anatomy in seventy-two cases. *Am Heart J* 1939;18:647-671.
13. Loisanse DY, Cachera JP, Poulain H, Aubry P, Juvin AM, Galey JJ. Ventricular septal defect after acute myocardial infarction: Early repair. *J Thorac Cardiovasc Surg* 1980;80:61-77.
14. Ellis CJ, Parkinson GF, Jaffe WM, Campbell MJ, Kerr AR. Good long-term outcome following surgical repair of post-infarction ventricular septal defect. *Australian N Zealand J Med* 1995;25:330-336.
15. Di Summa M, Actis Dato GM, Centofanti P, Fortunato G, Patane F, Di Rosa E, Forsennati PG, La Torre M. Ventricular septal rupture after a myocardial infarction: clinical features and long term survival. *J Cardiovasc Surg* 1997;38:589-593. ■

Drs. Siddiqui, St. Pierre and Talley are from the department of internal medicine and division of cardiology at the UAMS Medical Center and the John L. McClellan Memorial Veterans Hospital in Little Rock.

Asim Ahmed Shah, MD



Professional Information:

Name: Asim Ahmed Shah, MD, DABFM

Address: 907 W. Main St., El Dorado 71730

Specialty: General psychiatry

Business affiliates/organizations: Member of Practice Research Network, American Psychiatric Association and American College of Forensic Examiners

Volunteer work: AMID, NIMH and other mental health organizations

Honors/Awards: Appreciation Award 1999 from the Delaware Psychiatric Center, Best Paper Award 1999 (Delaware) on "Sexual Effects of Psychotropics," Diplomat American Board of Forensic Medicine and American Psychotherapy Association

Personal Information:

Spouse: Nayyar Asim

Children: Alizay Ahmed Shah, 3

Date and place of birth: Oct. 9, 1966, in Karachi, Pakistan

Hobbies: Traveling, reading and music

Asim Ahmed Shah, MD, recently joined the Neuropsychiatry Associates of South Arkansas and works in the main office in El Dorado.

Moving to El Dorado has been a good change for Dr. Shah, he says, including getting more involved with the community.

With only a few psychiatrists in the south Arkansas area, Dr. Shah stays busy traveling across the southern region of the state.

Before moving to Arkansas, Dr. Shah lived in Delaware where he won numerous awards for his study and involvement in the field of psychiatry. In 1999, Dr. Shah received the Appreciation Award from the Delaware Psychiatric Center and the Best Paper Award for his paper on "Sexual Effects of Psychotropics."

Dr. Shah is a member of the Practice Research Network, American Psychiatric Association and the American College of Forensic Examiners. He has been a volunteer for AMID, NIMH and other mental health organizations. Dr. Shah also is a diplomat to the American Board of Forensic Medicine and the American Psychotherapy Association.

One of Dr. Shah's main interests is psychoanalysis, which he studied in Philadelphia, and herbal medicine. He has done research and written a paper on St. John's Wort, which was published two years ago.

To take a break from work, Dr. Shah enjoys traveling with his wife, Nayyar Asim, and 3-year-old son Alizay Ahmed Shah, reading and music. He also enjoys writing about psychology. ■

PEOPLE+EVENTS

HONORED

Dr. Biondo Honored for Community Service

Dr. Raymond Biondo of Sherwood was one of several winners of this year's Channel 4 Community Service Awards. Dr. Biondo received his trophy from on-air talent Denise Whitaker at the 22nd annual awards ceremony. The event was in the Clinton Ballroom in Arkansas' Excelsior Hotel and featured Gov. Mike Huckabee, who presented the Distinguished Citizen Award to former U.S. Sen. David Pryor.

Dr. Biondo received \$500, which went to his favorite charities: \$300 to the Boy Scouts and \$200 to AHCAF.

Physician's Recognition Awards Presented

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMS recipients for May 1999 include **Dr. Jodi Adler**, Little Rock; **Dr. Paul Bean**, Little Rock; **Dr. Janina Budura Bonwich**, North Little Rock; **Dr. David Brooks**, Springdale; **Dr. Ricky Cameron**, Springdale; **Dr. George Covert**, Foreman; **Dr. Bernard Ferrer**, Little Rock; **Dr. Maria Luisa Fogata**, Little Rock; **Dr. Brad Johnson**, Springdale; **Dr. Rimantas Kazakevicius**, Hot Springs; **Dr. David King**, Fort Smith; **Dr. David Knutson**, Little Rock; **Dr. Rhonda Merchant**, Little Rock; **Dr. Malwinder Singh**, Little Rock; **Dr. Robert Smith**, Bentonville; and **Dr. Thomas Whiteside**, Little Rock. ■

OBITUARIES

Dr. C.P. McCarty

Dr. Charles Patrick McCarty, 79, of Helena died July 12 in Memphis.

He served Phillips County for 44 years before retiring, including several stints as chief of staff at Helena Regional Medical Center. He also was on the board of directors of Helena National Bank for 40 years and a member of Helena First United Methodist Church. In 1992, Dr. McCarty was the recipient of the Arkansas Hospital Association Distinguished Service Award.

Dr. McCarty graduated from the University of Tennessee Medical School at Memphis and Mississippi State University at Starkville, Miss.

Survivors include his wife of 57 years, Mildred Buchanan McCarty of Helena, and children and their spouses, Pat and Bankie McCarty of Osceola, Roger and Judy Deshaies of Memphis, Charlie and Kate Foster of Jackson, Tenn., Phil and Fay McCarty of Little Rock and Mike and Anita McCarty of Osceola.

Dr. Timothy A. Wilson

Dr. Timothy A. Wilson, 42, of Texarkana died July 5 at his home.

He was on the emergency room staff at Mena Medical Center and served in the U.S. Army. Dr. Wilson graduated from the University of Mississippi Medical School in Jackson, Miss., in 1984 and served his residency at Dwight David Eisenhower Hospital in Augusta, Ga.

He was a member of Beech Street Baptist Church and the American Medical Alliance.

Survivors include his wife, Elizabeth Wilson of Texarkana; his parents, J.D. and Edna M. Wilson of Hot Springs; two stepsons, Chris Meeks of Dallas and Casey Meeks of Oxford, Miss.; and stepdaughter Charity Lowdermilk of Prescott. ■

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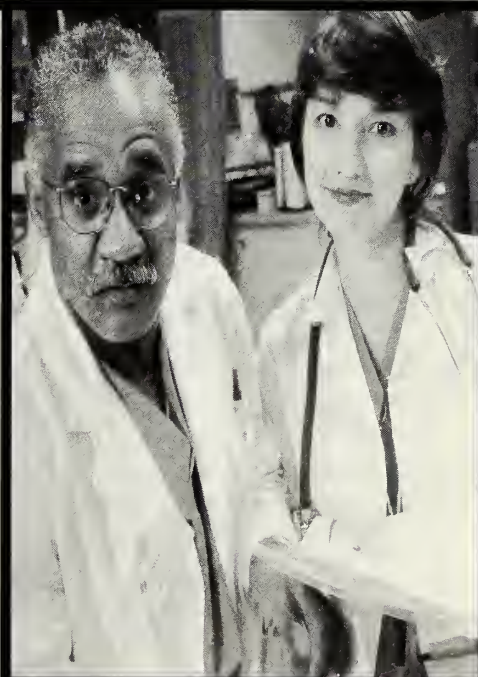
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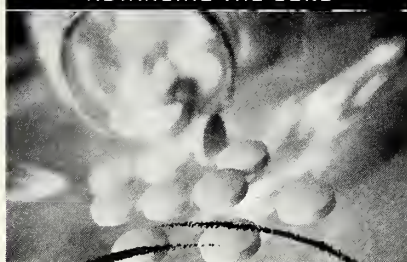
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Think of heading east next time a few free days become available and rest and relaxation are the goals. One of the sometimes overlooked gems of the Arkansas State Parks system is Village Creek State Park, 13 miles north of Exit 242 (state Highway 284) on Interstate 40 near Forrest City.

Village Creek doesn't have the stunning views of the Ozark or Ouachita mountains, but it is tucked away in the bumpy terrain of Crowley's Ridge. Trails take walkers under a canopy of a wide variety of hardwoods, and Austell and Dunn lakes supply fine fishing for bass, bream, crappie and catfish. Boats are available for rent, kids can enjoy a playground and beach, and a driving range allows golfers to knock a few balls around. The visitor center explains the terrain and history of the area, a gift shop has souvenirs, a small store has necessities, and bikes are for rent.

Ten cabins with kitchens and fireplaces can make a stay downright luxurious. The park also has plenty of campsites.

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Vol. 96 No. 5

October 1999

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THE Journal

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Highlights from speeches given at the University of Arkansas for Medical Sciences' White Coat Ceremony for first year medical students.

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The state's program for educating and treating low-income women with breast cancer is seeking physicians to serve as providers.

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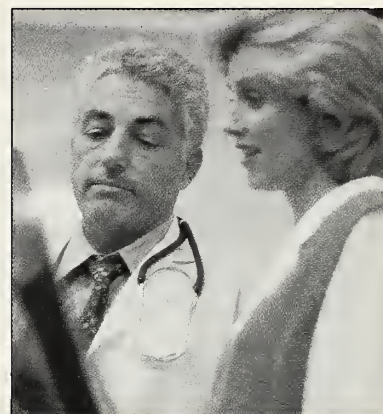
A research trial at UAMS is working to determine the effects of tamoxifen vs. raloxifene in treating breast cancer.

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Two Little Rock brothers, Drs. Gary Talbert and Michael Talbert, are helping women battle breast cancer in two different fields — reconstructive surgery and radiation oncology.

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Dr. Ronald Blachly of Jonesboro serves on the BreastCare board of directors and is working to incorporate the latest research into his practice.



BreastCare physicians are helping increase the amount of women screened for breast cancer.

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Good patient care requires careful documentation of ongoing treatments and evaluations.

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LETTERS

Caduceus vs. Aesculepius

Dear Lee (Abel):

I noted with interest your editorial in JAMS [July 1999] concerning the origin of the caduceus as the "well known symbol for the medical profession."

When I came to work here in 1985 as executive director of the Arkansas Caduceus Club — Medical Alumni of the University of Arkansas, one of the first hornets nests I encountered was our name. Jack Whisnant, a graduate who is now at The Mayo Clinic, wrote a particularly scholarly letter, and I followed up on his comments by going to the UAMS Library for further information.

The caduceus, I read, was the symbol of Hermes, or Mercury, the patron of thieves, gamblers and ambassadors. It is theorized that it was adopted as a medical symbol on the scant grounds of the noncombatant status of ambassadors and of physicians. The military, when challenged, responded that the caduceus, with its twin serpents and twin wings, was more pleasing in its regularity of form than the alternative, the staff of Aesculapius, the Greek god of medicine, with its single serpent entwined around a somewhat crooked staff and with no wings.

There is a ton of research on this — papers and, indeed, whole books.

So what was a brand new alumni director to do? Compromise, of course. We retained the name Arkansas Caduceus Club because it was instantly recognizable by our members and surrounded by a nice aura of respectability (and, we like to think, credibility). But we use on our logo the more appropriate staff of Asclepius.

Maybe the next director and his or her board will have enough nerve to change our name to the Arkansas Aesculepius Society. It was hard enough for me to learn to spell caduceus — nobody seems to know how to spell As/Aes/c/cu/lap/lep/ius)!

Sincerely,

Janet T. Honeycutt (Mrs. W. Mage Honeycutt)

Dear Mrs. Honeycutt:

Thank you for your letter, the article¹ and the notes. Egad, I didn't realize how little I knew! As I mentioned in my article, I had never given the caduceus much thought until I happened upon a story about the caduceus in a novel. In preparation for my article, I did some reading about the caduceus, but my research was perfunctory (lack of time, lack of interest, laziness). It sounds like your research was quite thorough. I had noticed the occasional use of a wingless one-snake staff, but I guess I just assumed this was some hurried shorthand caduceus (an impressionistic caduceus?). I was unaware of the apparently heated "two snake vs. one snake" controversy.

I have learned from the information you sent that some physicians have objected to the use of the caduceus because Hermes is the patron of thieves and the god of commerce (and usually depicted with a fat money purse)¹. This image, they argue, is not an appropriate one for physicians. Of course, some

cynics might claim he is altogether the perfect god to represent us. It's understandable that some physicians might prefer a symbol from a different Greek god to represent us. (Maybe Zeus' royal scepter?)

Even though the historical record might best support the staff of Aesculapius, I doubt the use of the caduceus is going to fade away. Perhaps some good can still come from this. As physicians, we see all kinds of people as patients. We will see "thieves, gamblers and ambassadors." Maybe the caduceus can serve to remind us that our task is to treat all our patients, the exalted and the low, with respect, kindness and to the best of our ability. Though we may at times pretend we are "better" or "more respectable" than others, the humanity we share with all our patients unites us with them far more than any particulars separate us.

I find the image of the two snakes balanced and in harmony on the caduceus a powerful one. The snakes can be seen as representing the two polarities of medicine, the art and the science. Or as I discovered, they can symbolize wisdom and knowledge (which aren't the same thing). To be skilled enough in the art and the science, to have enough wisdom and knowledge seems to be the central challenge of medicine. This is what I was trying to explore in my article.

In my article I wrote that the caduceus is "a" (not "the" as you quote me) well-known symbol of the medical profession. There are, of course, many symbols for physicians such as the stethoscope or those funny looking head mirrors ENT doctors (used to?) wear. In this issue of JAMS, we highlight some of the speeches given during UAMS' White Coat Ceremony, during which medical students are given a white coat to mark their entry into the medical profession. Receiving the white coat is an important and memorable experience for the students.

But to some patients the white coat is not a healing symbol; it is a fearsome image and their blood pressure shows it. Symbols can inspire us and unite us and, unfortunately, they can also divide us. We even can kill each other because of symbols. Maybe the most important thing to remember is that people are more important than symbols. If we become too dogmatic about our symbols, we start to serve them rather than they us.

I think you may be due an apology from we physicians for the "hornets nest" you ran into (or maybe it could be stated that you stepped into a snake pit) when you were just starting your job. If the compromise you made restored good will, then it seems a wise compromise to me. Keep up the good work and thanks again for taking the time to contribute to my continuing medical education.

Sincerely,

Lee Abel, MD

¹Rakel RE: *One Snake or Two?*. JAMA 1985; 253:2369

Note: The various spellings of Aesculepius are CQ

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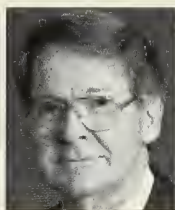
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COMMENTARY



BreastCare Can Save Lives

SAMUEL E. LANDRUM, MD

BreastCare is a program that should be of great benefit to women in Arkansas. Nothing alarms a woman more than a concern about problems with her breasts. Also, there is a low rate of screening mammography performed in Arkansas. This program addresses both needs. We are encouraging AMS members to participate.

Established by the Arkansas Legislature in 1977 with funding, administered by the Arkansas Department of Health and overseen by eight members of a board appointed by Gov. Mike Huckabee. BreastCare has been "on the streets" for eight months.

Unexpected problems with implementation have been corrected as far as possible and allowed by legal requirements, and obstacles for providers and patients have been reduced. Early doctors and clinics were slow to sign up for these services.

Enrollment: The patient must enroll before services can be performed. The toll-free phone number is (877) 670-CARE, answered day or night. An enrollment card is provided.

BreastCare is for women older than 39 who have no insurance and have an income less than 200% of the poverty level. Of almost 4,000 enrollees through July, about half have been referred by providers in doctors' offices, AHEC, local health clinics and health departments.

Services: BreastCare covers the expenses of screening mammograms, more specific images as indicated, biopsies by various techniques, operations, lab studies, adjuvant therapy and radiation therapy. It does not provide services for a new enrollee that is found to have metastatic breast cancer. It is feared, appropriately, that the funding would be exhausted without enough to treat the survivable or curable cases without this restraint.

Reimbursement: The Medicare fee schedule is applicable for services, and billing instructions are very thorough in the provider's manual.

Impact: The legislation was enacted to provide for patients who, for numerous reasons, have no access to needed examinations or evaluations of their breasts. The early reports show that 18 breast cancers have been treated. This datum derives from claims already processed, so there are undoubtedly more cases.

Recently data from 1982-1995 about patients who were treated at two New York institutions and what factors were associated with poor prognosis were analyzed. Poor survival rates of African-American breast cancer patients seem to relate to advanced stage at presentation and young age. The authors suggest that screening mammograms at an earlier age should help. This group of women is certainly one in Arkansas that lives in areas that have less availability of health care and whom BreastCare should reach. Some volunteer organizations are helping by transporting patients and helping them enroll in BreastCare.

October is a month when emphasis on breast cancer is higher. It also is when nominations for the Josetta Wilkins Award are sought. This award recognizes individuals or organizations that made outstanding contributions in the fight against breast cancer. Nominations should be sent to the Arkansas Department of Health, Breast Cancer Control Program.

More importantly, it is time for doctors who care for patients with breast problems to sign on as providers if they have not already done so. All of us need to do all we can in this work. ■

Reference: El-Tamer MB, Homel P. and Wait RB., "Is Race a Poor Prognostic Factor in Breast Cancer?" *Jl Am Coll Surg* 1999; 189: 41-45.

Dr. Samuel E. Landrum is a retired general surgeon from Fort Smith. Dr. Landrum is a member of the editorial board for The Journal of the Arkansas Medical Society.

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FROM THE STAFF



100 Physicians to Take Part in Planning Effort

By DAVID WROTEN

Beginning this month, more than 100 physician volunteers will take part in a project to set the course for the Arkansas Medical Society as we move into the next millennium.

AMS President Lloyd Langston, MD, of Pine Bluff, has appointed a steering committee to oversee this long-range planning effort. The steering committee is co-chaired by Drs. Carl Chambers of Little Rock and Scott Ferguson of West Memphis.

Other members of the steering committee are listed below:

Omar T. Atiq, MD, Pine Bluff

Joseph Beck, MD, Little Rock

Donald G. Blagdon, MD, Camden

Daniel Davidson, MD, Searcy

Denise R. Greenwood, MD, Little Rock

Anthony Hui, MD, Fayetteville

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Ex-officio: AMS past presidents Michael Moody, MD, Salem; Charles Logan, MD, Little Rock; J. Larry Lawson, MD, Paragould; and William N. Jones, MD, Little Rock.

The significance of this project cannot be overemphasized. Times are changing. Physician reimbursement is on a downward trend. Young physicians are going into large group practices and employment situations. Many physicians — especially those in solo and small groups — are being left out of managed care networks. Traditional grass roots organizations such as the county medical society are disappearing. Technology is changing how we communicate and how we conduct business.

The participants in this long-range planning project will study these and other trends facing Arkansas physicians and then develop strategies to meet these challenges head on.

The Arkansas Medical Society has a great history of representing Arkansas physicians. Whether it's in the legislative and regulatory arena or addressing public health issues such as HIV or indigent care, Arkansas physicians expect success — and get it through the AMS. But as Will Rogers once said, "Even if you're on the right track, you'll get run over if you just sit there."

On Oct. 13, 2000, the Arkansas Medical Society will celebrate 125 years of representing our state's physicians. The AMS didn't get to be that old by simply sitting on the tracks. It takes effort.

The 100 volunteers for this project deserve our gratitude and appreciation, but they also need your support. They are giving up time from their families and their practices for your future. If asked to complete a survey or to offer an opinion on a particular issue, the few minutes you take will make their task easier, and in the long run, it will help keep your medical society on the right track. ■

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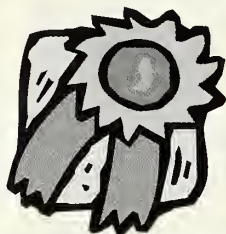


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IN + THE + NEWS



CARTI Is Approved By ACS Commission

The affiliation of Central Arkansas Radiation Therapy Institute and the Arkansas Cancer Research Center has been granted Integrated Cancer Program status by the Commission on Cancer of the American College of Surgeons.

Commission on Cancer gives approval only to facilities that voluntarily commit to providing the best in diagnosis and treatment. Facilities approved must have a standing cancer committee, hold weekly cancer conferences, participate in patient care evaluation studies and maintain a cancer registry. Approval includes an on-site review every three years.



Children's Hospital Earns Safety Award

Arkansas Children's Hospital is the recipient of the Ray Carnahan Award for excellence in fire safety community education for 1999. The award is named for the state fire marshal.

ACH teaches fire and burn safety and prevention through its community outreach department and the ACH Burn Center. The Fire Safety House, burn prevention classes and educational materials given to teachers and firefighters are some of the tools used by the hospital. The latest program is the Juvenile Firesetter Intervention Program, which educates young people who show tendencies to play with fire.



FTC Shines Light on Deceptive Ads

The Federal Trade Commission has identified deceptive health care advertisements on the Internet and cautions consumers.

Misleading offers include treatments for heart disease, cancer, AIDS, diabetes, arthritis, multiple sclerosis and other conditions. The FTC encourages consumers to ask a simple question before making purchases: If a medical breakthrough really has occurred in the treatment of a serious illness, would the news be announced first in an ad?

Watch for phrases such as "scientific breakthrough, miraculous cure, secret formula, ancient ingredient"

and similar descriptions. Other tipoffs include a long list of symptoms a product can cure, limited availability, testimonials and claims that the government, medical profession or scientists have suppressed the product.

To lodge a complaint or ask questions about a product, fill out the FTC form at www.ftc.gov or call (877) 382-4357 (FTC-HELP).

FDA Makes Changes to Mammographies

The U.S. Food and Drug Administration has changed mammography regulations to require facilities to send patients summaries of mammogram reports, written in lay terms, within 30 days of exams.

Also, in cases of suspicious results or results that are highly suggestive of malignancy, facilities are required to see that the patients receive results as quickly as possible.



State's Uninsured Rate Worst in U.S.

According to the Employee Benefit Research Institute, the uninsured rate among nonelderly Arkansans was tops in the country in 1997.

About 28% of nonelderly Arkansans had no health insurance, compared with the national rate of 18%. Also, 27% of the state's children were uninsured — the highest rate in the country. Thirty-eight percent of the state's self-employed persons were uninsured. Eight percent of workers in government jobs in Arkansas were uninsured; 64% of workers in agriculture and mining jobs were uninsured.



AFMC Working Under HCFA's 6th Scope

The Arkansas Foundation for Medical Care, the state's Medicare Peer Review Organization, has begun activities under the Health Care Financing Administration's 6th Scope of Work. Projects will involve acute myocardial infarction, congestive heart failure, pneumonia, stroke/transient ischemic attack/atrial fibrillation, diabetes and breast cancer.

HCFA's Payment Error Prevention Program also is included in the contract. AFMC will check inpatient hospital claims for correct coding and medical necessity, work with hospitals and physicians on criteria for payment errors and conduct educational programs. ■

DAYS GONE BY

A Call to Action

We at the Arkansas Medical Society are concerned with the lack of enthusiasm and participation at the county level. With few exceptions, most county medical societies have become totally inactive or ceased to exist completely. This has certainly contributed to the demise of collegiality among physicians and a weakening of grassroots participation in the profession. Perhaps today's physicians should take heed to the remarks of AMS President Dr. J. W. Hayes of Eureka Springs in his address to attendees of the Arkansas Medical Society annual meeting of 1899:

Gentlemen, I now approach the most important subject to which our attention can possibly be directed—The County Medical Society. Without this, no medical organization whatever can exist. The state society lives only through this medium; without it the American Medical Association would crumble and fall. Every physician in this broad land has the gracious privilege of upholding this grand superstructure. The doctor who lives out his life without ever appreciating this privilege, or realizing the responsibility devolving upon him to help, aid and assist organized medicine in its every phase, is just that far a failure at that. What could the Arkansas Medical Society do with 75 organized, well equipped societies? Why, just anything we wanted to do—the people and the legislature would all be ours.

If something could be done to stimulate county societies to greater zeal and promptness, the whole work would be accomplished.

The germ on which disease is builded is ignorance; wisdom then is health's foundation stone. It is necessary that each physician should be an enthusiastic advocate for even a better and more scientific medical education, as time advances and facilities for the betterment of mankind increase. ■

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White Coat Mentors Urge Future Physicians to Uphold Ethics, Morals of Medical Profession

Highlights from the August White Coat Ceremony at the University of Arkansas for Medical Sciences



Dr. Langston

"Today, we still follow a code of ethics, but in the modern world of medicine, we often find that ethical considerations that were very clear years ago seem to be less clear today. As you progress toward graduation, you will find yourself struggling, along with the rest of us, to decide what is and is not ethical as we deal with politics, abortion, cloning, genetic engineering, managed care and numerous other issues undreamed of by our predecessors in medicine when the subject of ethics was considered. Now

we even have specialists in medical ethics who would purport to clarify our concerns and answer our questions about ethics.

The best suggestion that I can offer is to always remember that your patients and their welfare must be first in your consideration. As physicians, we are entrusted by our patients with their most valuable possessions — their life and physical well-being. Don't ever take that trust and responsibility lightly. If this responsibility is foremost in your mind, then ethical conduct will be much simpler and much more clear."

— *Lloyd Langston, MD*

President, Arkansas Medical Society



Dr. Wilson

"During the past 50 years medicine has changed. We have experienced a magnificent growth in the technology and science of medicine. But the medical profession is still much more than science and technology, however wonderful they are and may become. Medicine is a human science with its roots feeding on compassion, caring, trust, ethics and values.

We need to emphasize the human qualities and the values so important in our profession. Several years ago, a clinical professor started and endowed a White Coat Ceremony at Columbia Medical School. UAMS is using this ceremony as a first step in emphasizing to you, our students, and to your families and friends that a balance between art and science is fundamental to our profession and to the practice of medicine.

The white coat is as much a symbol of the profession of

medicine as is the stethoscope. It stands in part for cleanliness and purity. This white coat signifies that we physicians are part of a learned profession dedicated to the treatment and care of our patients. It means the patient can trust us and be assured that we are skilled and dedicated practitioners of the art and science of medicine.

I am pleased that the White Coat Ceremony is being co-sponsored by the Arkansas Medical Society, which concurs with us that honor, integrity and compassion, as stated in the oath, are core values in the practice of medicine. Your fellow students, your teachers and your colleagues in the practice of medicine all join with you tonight to emphasize the importance of the art of medicine and the expectations associated with the white coat regarding values, trust and service."

— *I. Dodd Wilson, MD*

Dean, College of Medicine,

University of Arkansas for Medical Sciences



Felton

"Your journey is not only academic, but also one into the world of ethical and moral issues regarding the care of your fellow human beings. Through experience you will develop your character, and your character will, in turn, define you and your practice of medicine.

For you, the Class of 2003, the mantle of professionalism and ethical behavior is passed tonight. Keep it with you throughout your medical training and practice. In a few minutes you will recite and then sign the Medical Student Oath, whose opening line professes that "In order to contribute to a spirit of moral and intellec-

tual development: affirming that honor, integrity, and compassion, are [your] highest ideals . . ." As you stand on the threshold of the path to become a doctor of medicine, I challenge each of you conscientiously to pursue a character, steeped in honor, and that you will conduct yourself with unquestionable integrity in all of your professional relations.

Tonight, receive these white coats and cloak yourselves with honesty, integrity, compassion and character. Hold fast to and develop these qualities that symbolize the way of life, and the virtues of a moral physician."

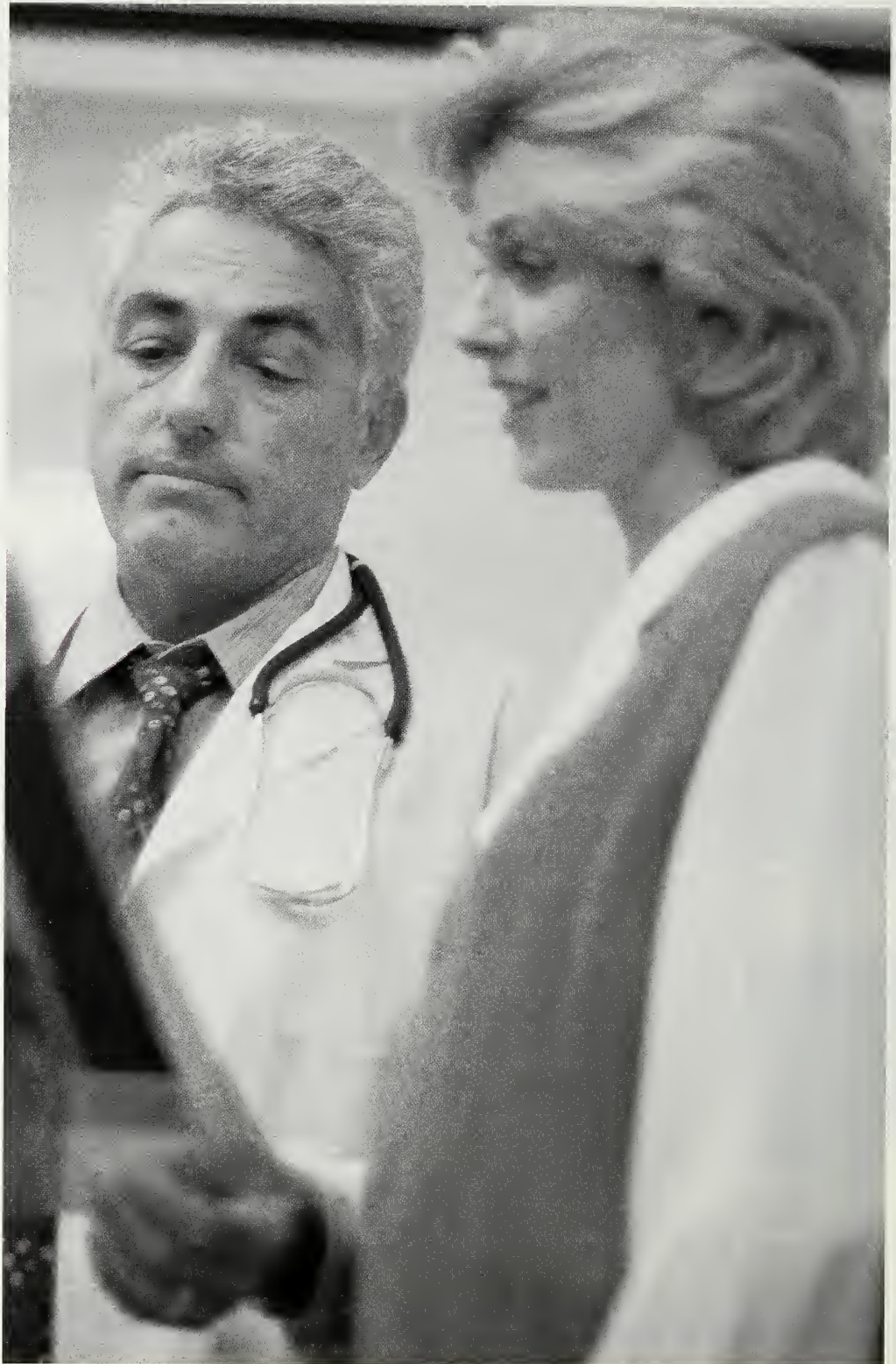
— *Daniel H. Felton*

Senior medical student and co-president of the College of Medicine; Honor Council, University of Arkansas for Medical Sciences

Women Gain Ground with BreastCare

BY NATALIE GARDNER

Program Ensures Screening, Treatment for Poor



About 400 out of 1,900 women diagnosed with breast cancer died in Arkansas during 1997. Concerned with the fact that many of these were indigent women with no access to breast cancer screenings or treatments, former state Rep. Josetta Wilkins of Pine Bluff encouraged the state Legislature to pass the Breast Cancer Act of 1997. Out of this act, BreastCare, a program to screen and treat breast cancer in low-income women, was created.

The program serves women age 40 and older who are at or below 200 percent of the federal poverty level and who are uninsured. BreastCare provides free regular mammograms, and if a woman is diagnosed with breast cancer, BreastCare provides free treatment, including surgery, chemotherapy and radiation. It does not provide services for a new enrollee that is found to have metastatic breast cancer because of fear that funds would be exhausted without enough left to treat curable cases.

The program, begun in February, is serving as a model for other states that want to create breast cancer programs that complement an existing federal program that pays for limited diagnostics but no treatment. BreastCare combines resources with the federal program, private

Clinical Study Tests Raloxifene

Researchers Optimistic About Reducing Breast Cancer

Does raloxifene decrease the likelihood of cancer?

That's a question the University of Arkansas for Medical Sciences is seeking to answer in a double-blind clinical trial, the Study of Tamoxifen and Raloxifene, or STAR.

In STAR, tamoxifen and raloxifene are compared for their effectiveness in reducing breast cancer in post-menopausal women 35 and older who are at increased risk of breast cancer. Tamoxifen, also known as Nolvadex, is a drug that has been used for reducing the incidence of invasive breast cancer in women at high risk for the disease. The drug, which has United States Food and Drug Administration approval for such use, has been studied for 20 years.

There is some belief that raloxifene, also known by the trade name Evista, may have the same ability, and the trial compares the effectiveness of tamoxifen with raloxifene for breast cancer prevention. Raloxifene has U.S. FDA approval for the use in prevention of osteoporosis in post-menopausal women. The study also seeks to determine how the side effects of raloxifene and tamoxifen compare. Researchers think raloxifene may have fewer side effects than tamoxifen.

More than 400 centers in the United States, Puerto Rico and Canada will enroll women in the STAR trial study like the one scheduled at UAMS. About 22,000 women are expected to participate in the trial study. Women can find out where other STAR centers are by calling the National Cancer Institute's Cancer Information Service at (800) 422-6237.

The STAR trial, supported by the NCI, is being conducted by the National Surgical Adjuvant Breast and Bowel Projects, which includes more than 6,000 medical professionals. The organization has successfully conducted large-scale, randomized clinical trials for 40 years.

Breast cancer is the most common cancer in North American women and is a leading cause of death, second only to cancer. Risk factors that are believed to increase a woman's chance of breast cancer include a family history of breast cancer, age, never having borne a child, having a first child after age 30, have a first menstrual period at an early age, a history of benign breast diseases that required bi-

opsies and other breast conditions, including lobular carcinoma in situ or atypical hyperplasia.

Women with high risk may want to participate and must be evaluated through a STAR risk assessment. The assessment is essentially a questionnaire on breast cancer history in the patient's mother, sister or daughter; the patient's personal history of breast biopsy, including common diagnoses; and the patient's reproductive history. To qualify for the trial, women must be at an increased risk of breast cancer and meet other study criteria.

The study will only include women who want to participate, and the NSABP stresses that participants should consult with their doctor, family and friends before signing up.

Before starting the study, women also must undergo the following routine tests, though if the patient has had one recently, it likely will suffice: a breast exam, a mammogram, blood tests and a pelvic exam. The tests can be performed at a doctor's office on an outpatient basis or at a hospital.

Women who are eligible and want to participate will be assigned to one of two groups randomly by computer. One group will take 20 milligrams of tamoxifen per day and a placebo that looks like raloxifene. Participants in the other group will take 60 milligrams of raloxifene per day and a placebo that looks like tamoxifen. Neither the patient nor the treating physician will know which drug the patient is taking.

The women will take the drugs daily for five years. During that time, the patient must have a breast exam every six months by a professional.

Participants should know there is a two to three times greater chance of developing cancer of the uterus when a woman is taking tamoxifen or other female hormones, but less is known about raloxifene. Women who have had a hysterectomy are not at risk for uterine cancer.

Some side effects include abnormal vaginal bleeding, pelvic discomfort or other pelvic changes. Other serious but rare side effects include stroke, and there may be other unpredictable side effects. ■

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"With this program in place, it is a very rare exception that a woman 40 and above would not get screening and [treatment] for breast cancer," said Dr. Fay Boozman, director of the Arkansas Department of Health, which administers BreastCare.

Since its February launch, BreastCare has received more than 18,000 calls from women throughout the state, and more than 4,000 of those women have been enrolled in the program, said Johnnie Holcomb, chairwoman of the Arkansas Breast Cancer Control Advisory Board, which oversees the program. Of the 4,000 enrolled, 15 women have been diagnosed with breast cancer and are receiving treatment.

Getting Physicians on Board

The program has recruited more than 300 physicians to participate in the statewide initiative, with more being added. Several Arkansas Medical Society members are on the Arkansas Breast Cancer Control Advisory Board. They include Dr. Samuel Landrum of Fort Smith, Dr. Ronald Blachly of Jonesboro, Dr. Robert Elliott of Searcy and Dr. Cynthia Ross of Little Rock.

"This is really for the benefit of our patients," Dr. Landrum said. "These patients are underserved in regards to breast cancer checkups. They don't come in for screenings, and when they do find out they have cancer, they ignore themselves because of money issues."

Dr. Landrum said the first few months of the program posed several problems with billing and excessive paperwork, but many of the kinks in the system have been fixed, and payment is now arriving on average 10 days after a bill is submitted, an improvement. BreastCare's service providers are paid a fee similar to that of Medicare.

"There's no economic benefit to doctors in being in this program," Dr. Landrum said. "It's more a sense of doing what's right."

A Union of Services

BreastCare is funded by an annual \$3.2 million appropriation from Arkan-



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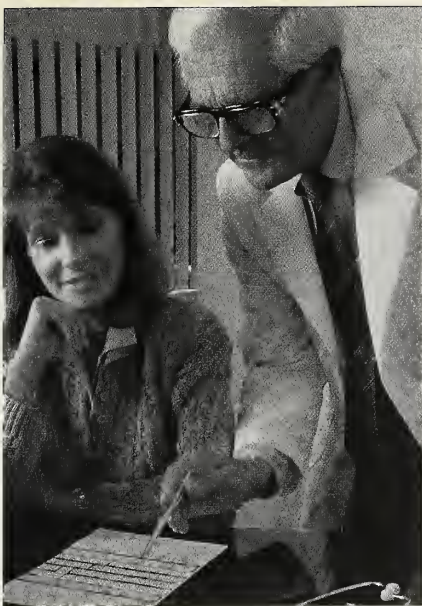
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— Dr. Fay Boozman

sas general revenue. Besides providing the screening and treatments, the program maintains a toll-free number, (877) 670-CARE, which is available 24 hours a day for breast cancer information, online enrollment, mammogram appointments and medical provider information. The staff determine a woman's eligibility and make an initial mammogram appointment for her while she is still on the phone. And for those women who are not eligible for the program, they receive a list of alternative, low-cost community resources and providers for women.

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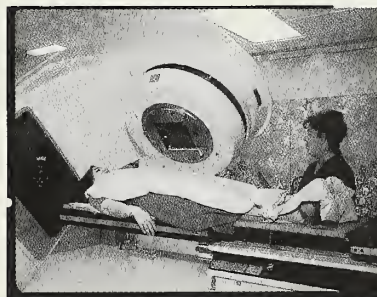
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sive program for women with breast cancer," Dr. Boozman said. "Before, with just the federal program, we could screen, but couldn't treat some because of age gaps. Now we have a good, solid union of all the different programs."

One of the key components of the program is performance evaluation. The data billing system tracks each patient's information, enabling BreastCare staff to track the progress the program makes in the fight against breast cancer. Eventually, the data will be used to measure BreastCare by the reduction in the incidence of breast cancer compared to benchmark data established by the University of Arkansas for Medical Sciences.

"Our goal is to decrease the morbidity and the mortality of breast cancer and get better each year," Dr. Boozman said. "This is a significant amount of money, and we need to be very conscientious of showing this money is doing what the Legislature set out to do."

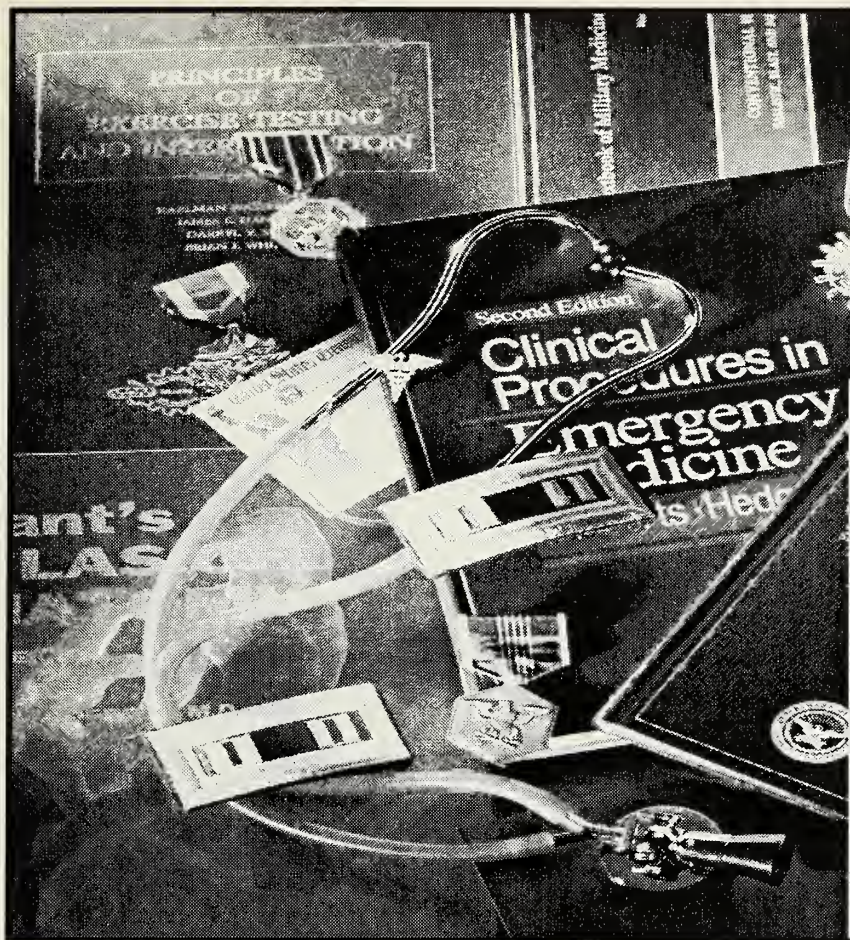
Reaching the Audience

BreastCare staff members are currently working on a grassroots campaign to let more women know about the services available to them. Reaching this target audience is one of the biggest challenges of the program. The board has set a goal of reaching 22 percent of its target audience by 2004. With the federal program, the goal is 15 percent.

To reach the women, BreastCare has used everything from programs on public television to signs on buses to color brochures. And physicians are a big part of the awareness campaign, urging their patients to find out more information about the program.

Another aspect of the program trains physicians to become more aware of breast cancer issues, even if a patient is not in for that specific reason, Dr. Boozman said. Building awareness among patients leads to more diagnoses and treatments of the disease, he said.


"There are good diagnostic ways of identifying breast cancer and good ways to treat it," Dr. Boozman said. "Breast cancer lends itself very much to a preventive model." ■




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Brothers Fight Breast Cancer in Their Own Ways

By JEFF WILLIAMS

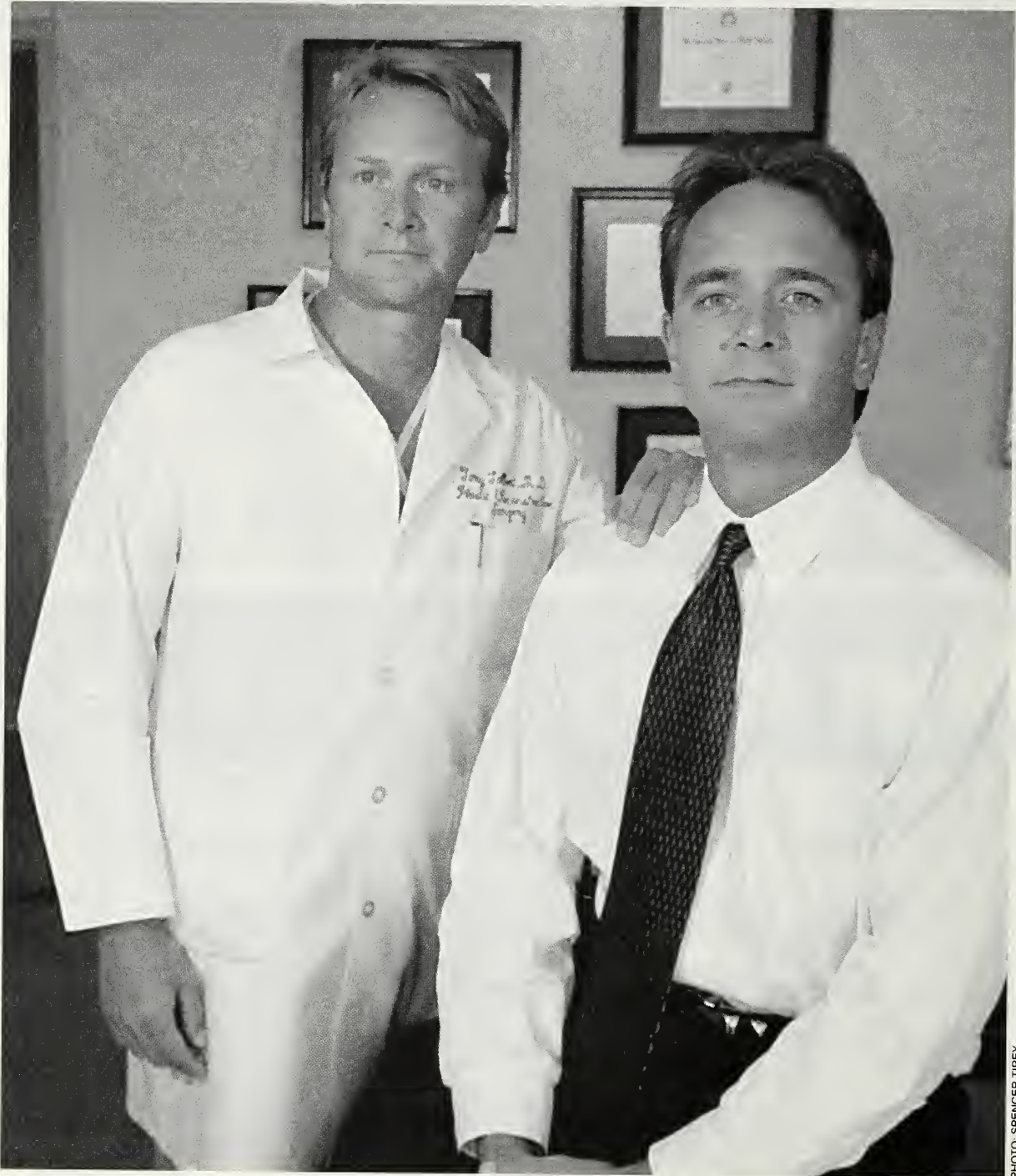


PHOTO: SPENCER TIREY

Dr. Gary Talbert, left, and his brother, Dr. Michael Talbert, usually don't see the same patients, although they fight together in the battle against breast and other cancers.

Gary is a breast reconstruction surgeon with Arkansas Plastic Reconstructive Surgery, a division of Surgical Clinics of Arkansas. Michael, an oncology radiologist, practices with Radiation Oncology Associates and is on the medical staff of Central Arkansas Radiation Therapy Institute.

"I work with all types of cancer," Michael says. "Gary does all types of plastic [surgery]. Breast cancer is the only area we overlap on."

Gary often works with patients who have undergone mastectomies and "desire reconstruction — whether it be implants or flaps — but also need radiation. The only time we treat the same patient is when those paths meet — after reconstruction and radiation therapy."

The brothers, however, agree that working in similar fields helps them better understand their patients and treatments. Michael says being able to call Gary about the background of a patient helps him decide about the timing of therapy and radiation.

"It's nice to be able to get him on the phone," Michael says.

Gary says the two talked recently, for instance, when Michael called Gary during surgery to discuss the timing of radiation therapy for a particular patient.

"I think [having a brother in medicine] has some real advantages," Gary says.

Although the two are linked by their medical professions, there's a stronger bond outside the office.

"We spend a lot of time together," Gary says. "Our wives are good friends."

Michael, 40, and Gary, 42, don't exactly finish each other's sentences, but they do seem to have similar tastes. Each one married a woman from Europe — Michael's wife is from Denmark; Gary's from Germany — and each is raising a similar family. Michael has two children, ages 6 and 8, and Gary has three kids, ages 4, 6 and 8.

The Talberts grew up in Jonesboro where their father was the long-time dean of the school of business at Ar-

kansas State University and their mother was an elementary school counselor. Michael and Gary graduated from ASU with degrees in zoology before enrolling at the University of Arkansas for Medical Sciences.

"I think we knew we wanted to go into the sciences," Michael says, recalling his

technique also greatly reduces scarring, and new procedures have dramatically cut surgery times and hospital stays.

"We're looking at new product lines and material sources to improve softness [of reconstructed breasts]," Gary says.

For Michael, the changes have been technical.

"The biggest change I've seen is the choice between mastectomy and conservative management. Fifteen years ago a mastectomy was conventional wisdom. During my training, lumpectomy and radiation was proven to be as effective [as mastectomy]. The tide has changed — the majority of patients don't have mastectomies today." — Dr. Gary Talbert

college days. "Probably my sophomore year I decided on med school."

"[My decision] came when I had to declare a major during junior clinical rotations," Gary says. "That's when you get a feel for different professions."

Changing Times

They've been practicing long enough to have seen major changes in their fields.

"The biggest change I've seen is the choice between mastectomy and conservative management," Gary says. "Fifteen years ago a mastectomy was conventional wisdom. During my training, lumpectomy and radiation was proven to be as effective [as mastectomy]. The tide has changed — the majority of patients don't have mastectomies today."

Gary says as late as 1989, when he left UAMS, reconstruction procedures after mastectomies often were put off for up to two years because of the fear that reconstruction would increase the risk or hide the recurrence of breast cancer. That approach also has changed.

"About 40 percent are having immediate reconstruction today," Gary says.

Reconstruction techniques have improved, too. Gary often uses skin flaps with tissue taken from other parts of the body to create breasts that are closer in size and symmetry to natural breasts. The

"The machines have changed," Michael says. "With computers we're able to give patients three-dimensional [radiation] treatment, treating them from six or eight angles to spare the normal tissue. The skin doesn't even turn pink. It's nothing like the radiation of 20 years ago. We look at reducing the amount of treatment to obtain the same results."

Michael says the toxicity of radiation has decreased and anti-nausea drugs make treatment much less of an ordeal and much less scary. And improvements keep coming.

"Before long we will be able to tell a computer what we desire and it will tell us how to treat — that's the direction we're heading," Michael says.

"With good surgery, good chemotherapy, for the early stages of cancer there's a 90 percent cure rate. The majority [of patients] will do well," he says.

We've heard the advice before but both doctors agree that three things often can save the life of a prospective cancer patient: self-examination, mammograms and early detection.

The cure for cancer — or at least a highly reliable method of prognostication — may lie in genetic testing. Michael says studies are under way to help find ways to identify patients before they have cancer. ■

Oncologist Encouraged by Cancer Advance

By ERICA MARSHALL

Dr. Blachly Steps Up the Case for Breast Cancer Screening



Ronald Blachly, MD, a Jonesboro oncologist, knows he may lose many battles in the fight against breast cancer, but that doesn't stop him from trying.

It is a very challenging field to be in. You don't win every battle, but when you do win, it's huge," said Dr. Blachly, who has practiced hematology and oncology for 14 years at the Northeast Arkansas Clinic in Jonesboro.

His clinic treats women who are in early, intermediate and advanced stages of cancer, a field in which advancements continue to occur in treatments. Among those include the use of lumpectomies, or removing a cancerous lump, rather than mastectomies. Today's breast cancer patients often undergo chemotherapy following surgery, and the technique is proving effective in reducing cancer recurrence as well as improving patients' survival chances.

Dr. Blachly and his partners are receptive to new treatments, once they have been endorsed by oncology experts. Dr. Blachly is a proponent of clinical trials, which investigate the use of new drugs in treating breast cancer. Such clinical trials provide valuable comparison data, he said.

"We should have more patients entered in clinical trials. I believe we could learn more if clinical trials were done more often," Dr. Blachly said. "We have learned more in the area of breast cancer in the past than other cancers. That is how we learn the best."

One of eight members of the Arkansas Breast Cancer Control Board, Dr. Blachly is the medical oncology representative on the board, which has the responsibility of overseeing a breast cancer awareness campaign called BreastCare. Dr. Blachly and his fellow board members are working to improve professional and public education on breast cancer while providing screening and treatment to patients who qualify. One of Dr. Blachly's specific areas of expertise is breast cancer screening, and he advises the board on that issue.

The predominant reason women do not receive breast cancer screening, Dr. Blachly said, is because their physicians do not recommend the screenings. Dr. Blachly said he

is encouraged by the progress in oncology, especially innovations in biological research and treatment that help explain how cancer develops.

"In this kind of treatment, you take baby steps to developing treatment, and then it starts to all add up," he said.

New drugs on the market have become more selective and less toxic, he said. That means patients will experience less serious side effects. One such drug recently accepted in oncology is Herceptin, an antibody treatment for cancer that is more specific in its attack on cancer than chemotherapy.

"There are exciting new developments in how to treat patients and [in] drugs, not only in the area of oncology but also [in] other branches of medicine," Dr. Blachly said.

Dr. Blachly has been on medical missions with his church to Guyana

and Romania to set up clinics for breast screening. He enjoys teaching family practice residents in the Area Health Education Center. When he's not working, Dr. Blachly likes backpacking and photography, and several of his works hang in the Northeast

sure comes when I know I really helped a person and they are appreciative; it is very rewarding."

There are several mementos and cards from grateful patients and family members on display in Dr. Blachly's office. They serve as reminders of the importance of the profession, he said.

"People want to be kept up to on the information available," Dr. Blachly said. To meet those demands, he personally goes to great lengths to explain to the patient and the patient's family

what types of treatment are available, all associated side effects and what course he believes is best suited for the patient.

With the development of the information age and the Internet, patients find being informed is easier. "All of the new information is very encouraging in focusing on patient care," Dr. Blachly said. ■

"The reality is that it is hard work and the hours are long, but the real pleasure comes when I know I really helped a person and they are appreciative; it is very rewarding."

— Dr. Blachly

Arkansas Clinic and his office.

Dr. Blachly said he became interested in oncology while in training at the University of Arkansas for Medical Sciences.

"I gravitated toward oncology because of the influential mentors I met during my training," Dr. Blachly said. "The reality is that it is hard work and the hours are long, but the real plea-

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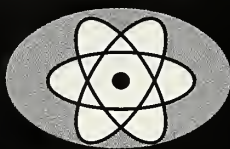
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RADIOLOGY



EDITOR: STEVEN R. NOKES, MD

AUTHORS: STEVEN R. NOKES, MD — W. BRADLEY PIERCE, MD — DANA C. ABRAHAM, MD — STEVE E. HARMS, MD

History

A 60-year-old nulliparous woman presented with progressive right nipple inversion. She had a benign biopsy seven years ago in this breast. Her breast examination was normal without a palpable mass. Right breast mammograms (Figure 1) reveal architectural distortion at the biopsy site, but this has been stable for six years. An ultrasound of the right breast was normal. An MR scan with contrast (Figure 2) was performed.

Diagnosis

Infiltrating lobular carcinoma.

Findings

The mammograms demonstrate a 1-cm area of architectural distortion in the inferior medial right breast 4-cm from the nipple at the 1992 biopsy site. This is stable on yearly mammograms from 1993. The MR exam reveals a 1-cm enhancing stellate mass with direct extension to the retracted nipple.

Mammograms of the right breast

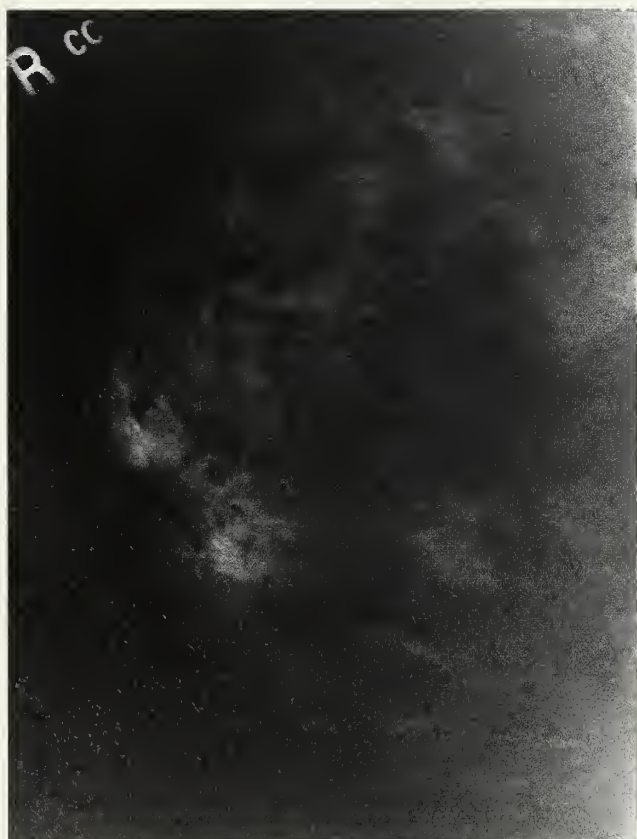


Figure 1 (a): CC

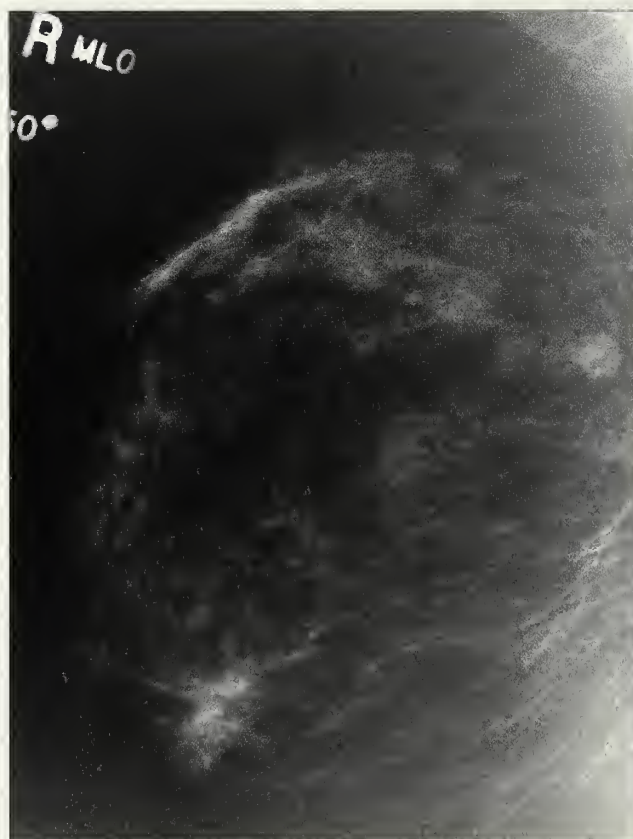


Figure 1 (b): MLO

Discussion

Breast cancer is the second leading cause of cancer death in American women. The false negative rate of mammography is between 5% and 10%. The limitations of mammography and ultrasound have prompted considerable interest in MR imaging of the breast, which is now playing an increasingly important role in management of breast disease.

No single standardized technique for breast MR imaging exists. In part this is due to the variety and complexity of available MR techniques. Most sites have settled on rapid acquisition, high-resolution sequences with fat suppression coupled with contrast enhancement. We use the RODEO (rotating delivery of excitation of resonance) technique because it efficiently combines fat saturation, T₁, magnetic susceptibility and magnetization transfer weighting with high spatial resolution. Spectral suppression and subtraction techniques have been found effective by others.

These techniques exploit the fact that most breast cancers briskly enhance following IV gadolinium administration. Gadolinium is a nonspecific contrast agent that is distributed in the extracellular space and accumulates in tissues with rich vascularity. Most breast cancers including intraductal cancers are highly vascular due to secretion of angiogenic molecules. Scars can enhance up to 18 months following surgery. In our case the biopsy was performed six years ago.

Currently, MR is not routinely used in breast cancer screening. Clinical indications include patients with known or probable breast cancer prior to breast conserving surgery, axillary metastases with a mammographically occult cancer, a developing mammographic asymmetric density with a negative ultrasound, evaluating preoperative chemotherapeutic response and patients with a diagnostic dilemma (ultrasound and mammography cannot answer the question), particularly with implants. ■

References

1. Muller-Schimpfle M, Stoll P, Stern W, Kurtz S, Dammann F, Claussen CD. Do mammographic sonography and MR mammography have a diagnostic benefit compared with mammography and sonography? *AJR* 1997;168:1323-1329.
2. Williams MB, Pisano ED, Schnall MD, Fajardo LL. Future directions in imaging of breast diseases. *Radiology* 1998;206:297-300.
3. Weinreb JC, Newstead G. MR imaging of the breast. *Radiology* 1995;196:593-610.
4. Pierce WB, Harms SE, Flamig DP, Griffey RH, Evans WP, Hagans JE. Three-dimensional gadolinium-enhanced MR imaging of the breast: pulse sequence with fat suppression and magnetization transfer contrast: work in progress. *Radiology* 1991;181:757-763.
5. Harms SE, Flamig DP, Hefley KL, et al. MR imaging of the breast with rotating delivery of excitation off resonance: Clinical experience with pathology correlation. *Radiology* 1993; 187:493-501.

Dr. Nokes and Dr. Pierce are associated with Radiology Consultants in Little Rock. Dr. Abraham is associated with Surgical Clinic of Central Arkansas, and Dr. Harms is associated with the University of Arkansas for Medical Sciences in Little Rock.

Contrast Enhanced MR images of the Right Breast Using RODEO

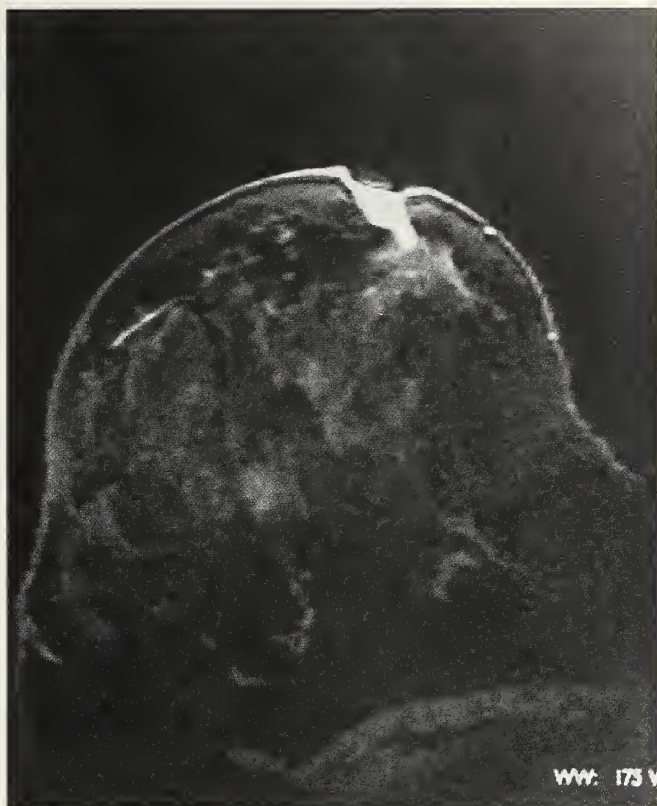


Fig. 2 (a): Axial

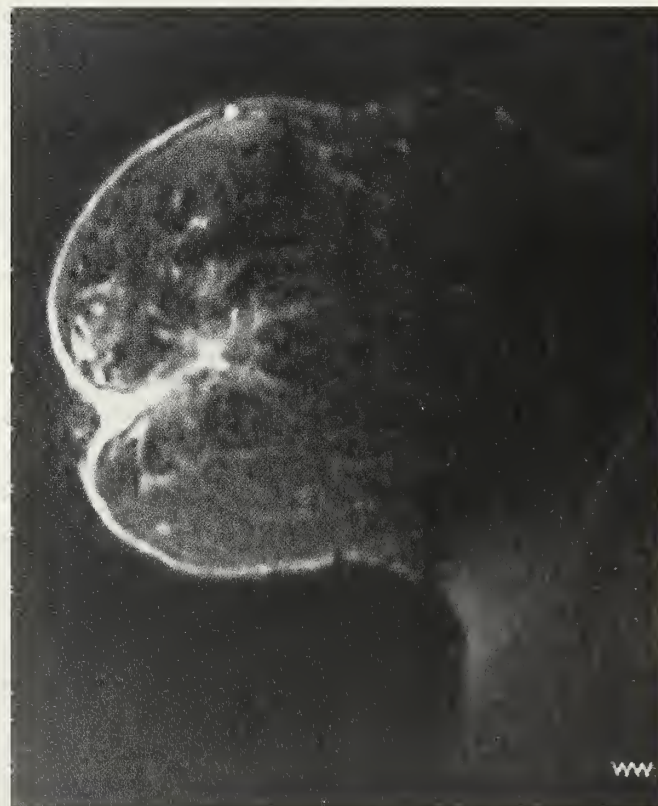
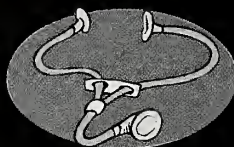


Fig. 2 (b): Sagittal

CARDIOLOGY



The Waves of the Electrocardiogram: Part 1 The P Wave

ALLISON SHAW, MD — JOE K. BISSETT, MD — J. DAVID TALLEY, MD

This is the first article in a series of discussions reviewing the principle features involved in interpreting electrocardiograms (ECGs). We begin with a discussion of the P wave and its abnormalities. The word abnormality, not enlargement, is used to describe these abnormalities of the P wave in order to distinguish physiologic and anatomic abnormalities (see New York Heart Association criteria in Table 1). Subsequent discussions will focus on other waves of the ECG.

Patient Presentation

A 55-year-old African-American man with a chronic obstructive pulmonary disease presented to the emergency department with two to three days of worsening shortness of air. The patient had been in his usual state of health with chronic dyspnea.

The patient was in moderate respiratory distress. There was dramatic jugular venous distension, bilateral crackles on lung exam, a loud S_2 with S_3 gallop on cardiac exam, and lower extremity edema. The ECG (Fig. 1) showed normal sinus rhythm, left atrial abnormality and right ventricular hypertrophy. An echocardiogram showed a calcific mitral valve with moderately severe mitral stenosis (mean transvalvular gradient of

15 mmHg, calculated mitral valve area of 1.1 cm^2 .)

Discussion

The development of the ECG in the early 1920s ushered in the era of modern cardiology. Einthoven (1860-1927) used the string galvanometer to record the cardiac wave forms which he later named P, QRS and T. For this accomplishment, he later received the Nobel Prize in physiology or medicine in 1924. The ECG measures the forces generated by the propagation of charges across the cardiac membranes (electrical potentials). The difference in resting membrane potentials records electrical activity of varying configurations.

Blood Supply to the Sinoatrial Node

The action potential begins near the sinoatrial node, a region of specialized atrial cells near the junction of the superior vena cava and the right atrium. The sinus node cells (P cells) are 5 to 10 μm oval cells that are capable of undergoing spontaneous diastolic depolarization and responding to changes in autonomic tone. The blood supply to the sinoatrial node is provided by the sinoatrial nodal ar-

tery.¹ This artery generally is a branch of the right coronary artery (in 60%), but may originate from the left circumflex artery (40%). The artery transverses the mid-portion of the sinoatrial node cells without direct branches.

Atrial Depolarization

With depolarization of the sinoatrial node, the action potential spreads across the right atrium, the interatrial septum and the left atrium in a leftward and inferior direction. The initial deflection of the P wave represents right atrial activation. The role of the internodal pathways is uncertain. It is generally accepted that the wave of depolarization in the right atrium can reach the AV node through an anterior (fast) pathway and/or a posterior (slow) pathway.

P Wave Axis

In normal sinus rhythm, the P wave should be upright in leads I and II (P wave axis between 30° and 80°). An atrial rhythm is present when the P wave vector is less than 30° or greater than 80° .

P Wave Width

The width of the normal P wave should be .07-.12 second. A P wave of

greater duration is seen in patients with an interatrial conduction disturbance commonly caused by delayed or prolonged left atrial activation (P mitrale). Mild notching of the P wave may be normal and is due to the transition of the depolarization wave from the right to the left atrium.

In a previous study, Morris and his associates evaluated 200 patients to determine accurate parameters for determining left atrial abnormalities.² Of these, 113 patients were normal and the remaining study group had known aortic or mitral valve disease. In this study, the authors noted that the product of the amplitude and the duration of the negative portion of the P wave in lead V1 (P terminal force) is more negative than -0.03 mm-second in 92% of the patients with left-sided valvular disease and in only 2.5% of the normal population.

P Wave Amplitude

Normal P wave amplitude should not exceed .25mV (2.5 mm). Tall and peaked P waves are characteristically suggestive of significant pulmonary disease (P pulmonale).³ These peaked P waves often are found in leads II, III and aVF. Though these peaked P waves are common in pulmonary disease, they may be seen in patients of slight body build. Though P pulmonale is clinically often associated with right atrial abnormality, it tends to be a nonspecific finding. In one study that included 100 patients with an electrocardiogram that had suggestion of P pulmonale, 49 patients had any underlying disease processes that could be

Table 1. Complete Problem List

1. Valvular disease

Etiology:	Mitral stenosis
Anatomy:	Dilation of RA, RV, and LA Normal left ventricular dimensions Calcified anterior mitral valve leaflet
Physiology:	Mild mitral regurgitation Mitral valve peak velocity 1.9m/sec Mitral valve peak gradient 15 mmHg
Functional Capacity:	NYHA Class III
Objective Assessment:	C

2. Chronic Obstructive Pulmonary Disease

thought to contribute to their development of a right atrial abnormality.⁴

Sensitivity and Specificity of the ECG in Detection of Atrial Abnormalities

In one autopsy study, nearly one-quarter of patients with left atrial hypertrophy had no electrocardiographic evidence of an atrial abnormality. As compared to echocardiography, the ECG has similar specificity but a sensitivity that hovers in the 70% range. The most specific ECG characteristics of left atrial abnormality are notching of the P wave followed by a negative P terminal vector. In right atrial enlargement, the positive predictive value of a QR pattern in lead V1 is 100% as compared to echocardiographic criteria.⁵

Next month's edition of "CCU: Cardiology Commentary and Update" will focus on common abnormalities of the QRS complex. ■

References

1. Mirvis DM. Structure and function

of the cardiac conduction system. In: Mirvis DM, ed. *Electrocardiography: A Physiologic Approach*. St. Louis, Mo: Mosby, 1993:3-17.

2. Morris JJ Jr, Estes EH Jr, Whales RE, Thompson HK, McIntosh HID. P wave analysis in valvular heart disease. *Circulation* 1964;29:242-252.
3. Gross D. Electrocardiographic characteristics of P pulmonale waves of coronary origin. *Am Heart J* 1967;73:453-459.
4. Chou T-C, Helm RA. The pseudo P pulmonale. *Circulation* 1965;32:96-105.
5. Mirvis DM. Atrial abnormalities, In: Mirvis DM, ed. *Electrocardiography: A Physiologic Approach*. St. Louis, Mo: Mosby, 1993:165-176.

Drs. Shaw, Bissett and Talley are from Department of Internal Medicine and Division of Cardiology University of Arkansas for Medical Sciences Medical Center and the John L. McClellan Memorial Veterans Hospital in Little Rock.

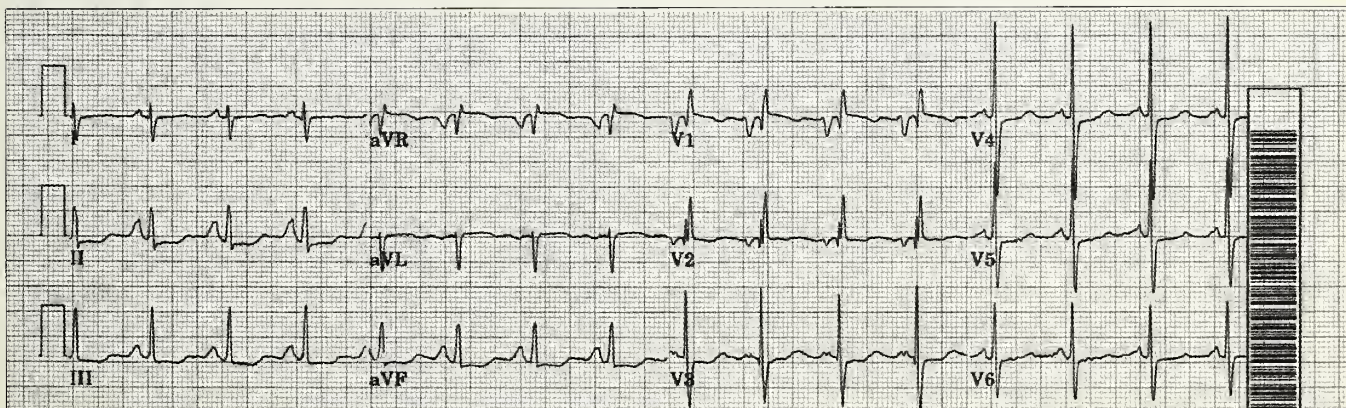


Fig. 1. The electrocardiogram shows left atrial abnormality due to anatomically severe mitral stenosis.

Outpatient Chart Documentation in Arkansas: A Report From Medicaid Managed Care Services

LAURA FERGUSON, MHSA
WILLIAM E. GOLDEN, MD

Author's Note: For the past five years, the Arkansas Foundation for Medical Care Inc. (AFMC), Health Care Quality Improvement Program (HCQIP), has focused primarily on inpatient projects. In 1996, we began expanding project information to include outpatient issues. Earlier ambulatory topics included management of thyroid disease, diabetes and flu immunization.

This AFMC project focuses on the prevalence of facility resources to manage hypertension and asthma as part of quality improvement efforts for Medicare and Medicaid patients in Arkansas. AFMC understands that outpatient facilities frequently lack an infrastructure to conduct outpatient chart audits in an efficient and effective fashion. This difficulty in data acquisition reflects a significant barrier. Nevertheless, certain processes and structural elements can be assessed to improve management of common outpatient conditions.

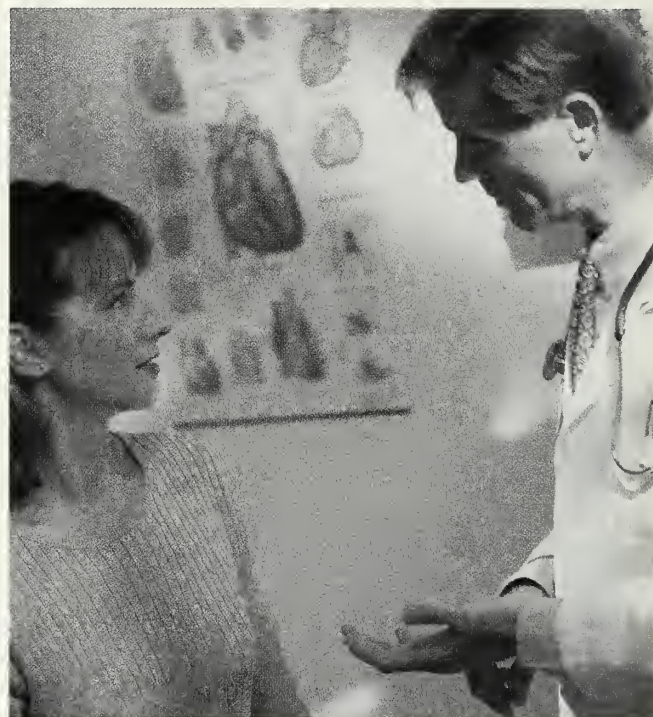
Good patient care requires careful documentation of ongoing treatments and evaluations. Such attention to record-keeping is important for assisting providers to review progress, communicate to consultants, justify payments and document quality of care. Simply put, medicine is now too complicated to rely solely on one's memory or brief phrases to describe a patient's condition.

Despite the acknowledgment that good record-keeping an important attribute, not all busy practices have systematically put into place procedures to assure the reliable documentation of every visit. These potential gaps in the patient record promote possible management errors, medicolegal liability and accusation of fraudulent billing.

Medicaid Managed Care Services, (MMCS) a division of the Arkansas Foundation for Medical Care (AFMC), works with the Department of Human Services to oversee the utilization and quality of services connected with the Medicaid Managed Care program and the ARKids First initiative. One effort in this program focused on the quality of medical record keeping documenting care for Medicaid recipients. This report documents results of initial survey activity.

Methods

MMCS staff developed a chart abstraction tool designed to identify proper documentation of billed services. Certain elements were felt to be mandatory for the provider to be in compliance with the conditions for participation in the state's



Medicaid Managed Care program. These data elements include patient identification, presence of record for date of service, history of present illness/chief complaint, physical exam, assessment/diagnosis, treatment plan, legible initial/signature, test results recorded and patient history.

In addition, we were interested in ascertaining whether other elements of record-keeping that can promote continuity and integrated, responsive care were a part of the office medical record. A complete listing of the chart items included in this review is presented in the attached element table.

Most of the elements in the MMCS abstraction tool are consistent with previous professional society recommendations and are included in office assessment programs such as the American Medical Accreditation Program of the American Medical Association. In addition, the abstraction tool and the plans for this review were shared with the Arkansas Medical Society and the Arkansas chapter of the American Academy of Family Physicians for their suggestions and endorsement.

Three clinic sites were identified to field test the abstraction document and to train nurse record abstractors on the elements. Data collection did not ensue until there was clarity in the abstraction tool and a high degree of inter-rater reliability

**Table 1:
MMCS General
Documentation
Chart Review
Project
Indicators**

Required Elements

- Record Present for Date of Service
- Patient Identification
- History of Present Illness/Chief Complaint
- Physical Exam*
- Assessment/Diagnosis
- Treatment/Plan
- Legible Initial/Signature
- Test Results Recorded
- Patient History
- Acceptable minimum includes notation of vital signs

Reference: Medicaid Provider Manual, Section 202

Non-Required Elements

- Problem List
- List of Current Medications
- Test Results Noted
- Allergies Noted
- Telephone Calls Noted
- One of Last Four Visit Notes has Vital Signs Noted
- Medicaid Number Documented in Chart

Report 1: Statewide Compliance by Region

REGION	Record Count	Required Elements	Non-required Elements	Overall Compliance
Northwest	465	84.4	68.5	77.4
Northeast	338	89.8	68.3	80.4
South	336	91.1	73.5	80.4
Central	210	85.0	72.4	79.5
Statewide	1349	87.3	71.0	80.2
Patient Identification		Record for Date of Service	History of Present Illness/Chief Complaint	Physical Exam
Northwest	456	438	432	422
Northeast	338	320	314	308
South	335	312	311	312
Central	133	197	185	312
Statewide	1262	1267	1242	1220
Assessment/Diagnosis		Treatment/Plan	Legible Initial/Signature	Test Results Recorded
Northwest	427	426	342	338
Northeast	312	316	310	318
South	311	310	311	307
Central	187	190	175	188
Statewide	1237	1242	1138	1151
Patient History		Problem list	List of Current Medications	Test Results Noted
Northwest	252	223	357	274
Northeast	197	187	255	232
South	245	173	321	257
Central	173	171	166	118
Statewide	867	754	1099	881
Allergies Noted		Telephone Calls Noted	One of Last Four Visit Notes has Vital Signs Noted	Medicaid Number Documented in Chart
Northwest	400	182	422	371
Northeast	269	134	231	307
South	261	105	312	300
Central	138	121	161	190
Statewide	1068	542	1126	1168

349 Records analyzed for 4 regions on 9/16/98

in the collection of the information.

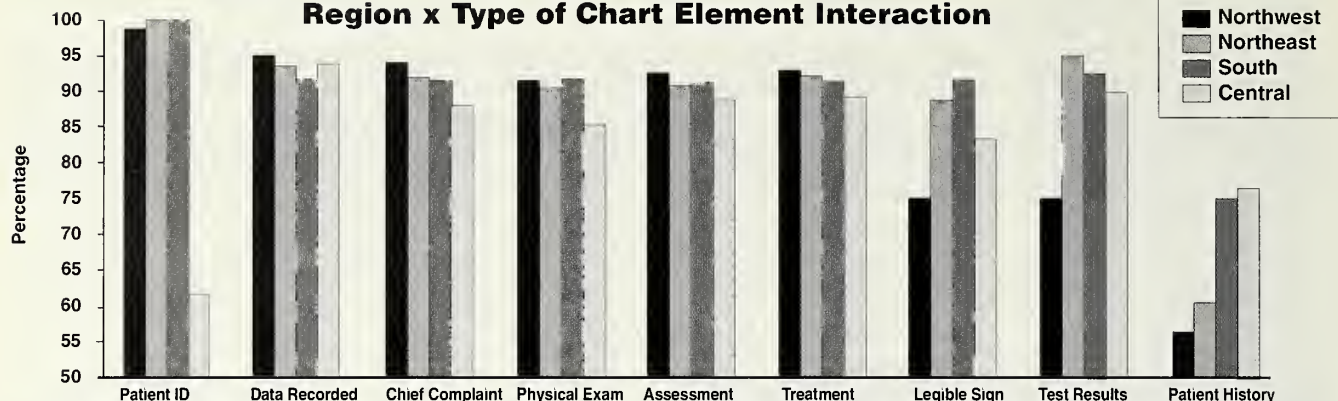
The state was divided into four regions — central, southern, northwest and northeast — and one review staff member was assigned to each. Physician names were then randomly selected from the Arkansas Medicaid provider list. To obtain the sample, each PCP was assigned a computer-generated random number. The sample of PCPs selected had the lowest

random numbers and also met the criteria of having filed a claim during state fiscal year 1998 for one or more office visits, EPSDT screens, ARKids preventive health screens, EPSDT physicals and/or EPSDT interperiodic medical screens. Eight percent of all PCPs were reviewed (exceeding the initial goal of 5%), for a total sample of 159 PCPs.

Once names were assigned, MMCS

reviewers mailed the selected PCPs in their regions an advance letter explaining the purpose for their upcoming visit. The following week, MMCS reviewers telephoned the PCPs in their regions to schedule a visit and provide a list of specific charts that were requested for review. MMCS selected to review as many as 10 charts per PCP based on a random sample of the PCP's recipient claims for 97-98.¹

Chart Audit Results: Region x Type of Chart Element Interaction



Required Elements Fig.1

For those PCPs who had seen fewer than 10 recipients during the reporting period, MMCS reviewed as many charts as were available.

During the on-site visit, the reviewer coded each tool element as either present (1) or missing (0), which meant the PCP could score between zero and nine on the required elements. Depending on the number of charts reviewed, the total points possible for each PCP was determined by multiplying the number of charts reviewed by nine. For example, those PCPs with 10 charts reviewed could score a total of 90 points. Because some doctors had fewer than 10 charts available, MMCS adjusted for the number of charts reviewed. Each PCP's final score was calculated as a ratio of the total number of points they had earned divided by the total points possible for the number of charts reviewed. This number was expressed as a percentage. For example, a PCP who had only one chart reviewed and earned six points (out of a possible nine) on that chart would score 66.7% ($6/9=66.7\%$).

Across the entire sample of 159 PCPs, the results indicated an 87.3 mean percentage of required elements found on reviewed charts with a standard deviation of 12.01%. To identify PCPs with significantly fewer required elements present in their charts than the average PCP (i.e., outliers), a two standard deviation criterion was adopted ($<63.24\%$). This criterion is commonly used and typically results in fewer than 5% of cases being identified. This criterion greatly reduces the likelihood that individuals will be identified who are not actually performing significantly below the comparison level.

Results

During the first-quarter reviews (July-

September 1998), the MMCS review staff visited 159 Arkansas PCPs and reviewed more than 1,300 charts. The statewide rate across both required and nonrequired elements was 80.2%, for required elements was 87.3% and for nonrequired elements was 71%. Overall results for required elements were encouraging, as seven had a 100% compliance rate. Seven PCPs scored two standard deviations below the mean.

Of the required elements, highest compliance (93%) was for patient identification and record for date of service categories. The two elements receiving the lowest scores were patient history (64.9%) and legible initials/signature (83.4%). Section 202 of the Arkansas Medicaid Provider Manual requires that PCP records contain "(a.) history and physical examination" with any new patient encounter. Likewise, the same section indicates that PCPs must include the "(f.) signature or initials of physician after each visit."

Figure 1, Chart Audit Results, provides a breakdown of each required element average per region. Additionally, the following summaries were derived based on each region's statistical findings:

A. Northwest: PCPs documented patient identification and record present for date of service significantly more than physical exam, assessment, legible signature, test results, patient history and treatment (patient identification only). Patient history was significantly lower than all other elements.

B. Northeast and South: In both of these regions, patient identification was significantly higher than all other elements, whereas patient history was significantly lower than all other elements.

C. Central: Although patient identification was the most commonly found documented element in the other three regions, it was the least found element for the central region and significantly lower than all other elements except patient history. Record present for date of service was documented the most, significantly more than all elements except test results. As in other regions, patient history was not well documented and was found significantly less than documentation of record present for date of service, chief complaint, assessment and treatment.

Statistical analysis of region effects for each element revealed:

A. The central region had a significantly lower percentage of documented patient identification than PCPs in any other region.

B. PCPs in the northwest were considerably less likely to have a legible signature than those PCPs reviewed in the northeast or south.

C. Northwest PCPs also were notably less likely to document test results in their patient charts than any other region.

D. Patient history was noted significantly fewer times in the northwest and northeast than in the south or central regions.

Discussion

The MMCS medical record project found that most providers keep reasonably complete documentation, but that substantial variation exists between offices. Our initial sample of physician offices documented a median compliance of 90% for the required Medicaid chart elements. A handful of offices supplied fewer than 65% of the required elements in the randomly selected dates of service. Report 1 shows a cumulative distribution of element

compliance in our office sample.

Following the study, MMCS mailed a one-page report to each PCP reviewed in the initial sample. This report provided the individual PCP's scores in required elements, nonrequired elements and overall compliance score. To keep results confidential, no names were included on the reports, only Medicaid provider numbers. MMCS provider representatives will schedule follow-up focus visits with those PCPs who fell below the 65% threshold (two standard deviations below the mean) in required elements to discuss documentation requirements and answer questions. MMCS anticipates improvement and thus, in order to record improvement, one of our reviewers will revisit those PCPs whose compliance rates indicate deficiencies in required chart documentation.

Beginning in January 1999, MMCS reviewers will increase the number of PCPs reviewed from 5% to 15%-25% per quarter. With this increase, we plan to visit each Medicaid primary care provider at least once a year.

Visited PCPs will receive a detailed record of their performance in comparison to regional and statewide norms. Also, immediately following the MMCS visit, the reviewer will conduct an exit interview with PCPs and staff to answer any questions and assist in identifying quality improvement areas. MMCS outreach staff will visit practices with substantial deficiencies in record for a review of the information and discussion of potential changes in office procedure. MMCS will share results of this program with the profession and its component societies. It is hoped that this educational format will result in uniform compliance with required record-keeping without the need for directive action and lead to better health care for the citizens of our state.

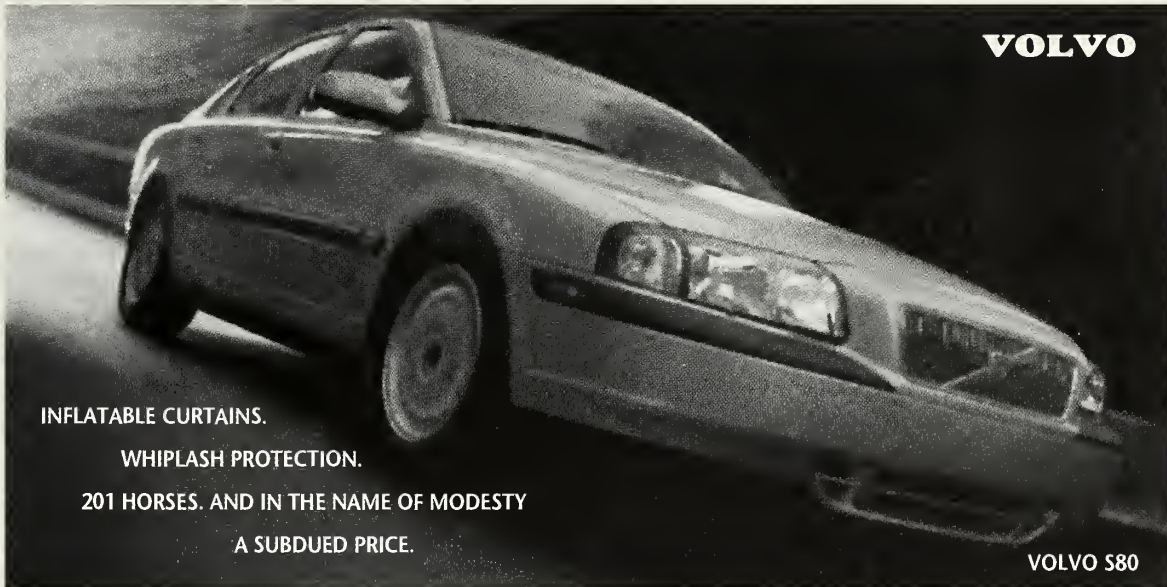
(Note: In order to ensure that the PCP's accuracy score was not biased by the number of charts reviewed, a Pearson correlation was first done to determine whether the number of charts reviewed per PCP was related to the percentage accuracy obtained. There was no relationship observed, $p > 0.040$, and thus, no adjust-

ment was necessary for number of charts reviewed.)

Laura Ferguson, MHSA, is with Medicaid Managed Care Services. Dr. William Golden is with the Arkansas Foundation for Medical Care and the University of Arkansas for Medical Sciences. ■

References

1. American College of Medical Quality. ACMQ Professional Policies, Documentation, Policy 10. March 1996. P.O. Box 34493, Bethesda, Md. 20820. Phone: (800) 924-2149.
2. American Medical Accreditation Program. Standards and Criteria, Medical Records; pages 8-10. Published 1997. American Medical Association. 515 North State Street, Chicago, Ill. 60610.
3. Medicaid Provider Manual. General Information; Page 11-6 Effective date: Oct. 1, 1990. Revised date: Sept. 1, 1997. Arkansas Department of Human Services: Division of Economic and Medical Services. P.O. Box 1437, Little Rock, Arkansas 72203-1437.



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Case Report: Rush to Judgement?

J. KELLEY AVERY, MD

After the patient's discharge from the hospital, the biopsy of the prostate was reviewed and it was the consensus of all the pathologists in the department, including the one who originally reported the case, that the diagnosis was benign prostatic hypertrophy.

A 65-year-old man gave his primary care clinic physician a history of gross hematuria for two weeks, emphasizing that he had the "flu" during this time, but was improving.

The documented physical examination was confined to the genitalia and the digital examination of the prostate. The physician recorded there was some tenderness on palpation of the epididymis and the prostate, and his impression was that the patient had some infection of the lower urinary tract, i.e., prostatitis and epididymitis. On this impression an appointment was made for the patient to be examined in the urology clinic. Six days later, a urologist saw and examined him.

The examination was not recorded by the specialist, but on the basis of the history, and whatever examination was done, an IVP and biopsy were ordered. Three days later the laboratory reported a PSA of 7.9 (normal 0-4.0) and four days later the IVP reported. It read, "Possible duplicated kidney on the left, with possible cyst or mass in the upper pole on the left kidney. Enlarged prostate gland, apparently causing bladder outlet obstruction Suggestion: Ultrasound of the kidneys for further evaluation."

As far as the documentation is concerned, there was no prebiopsy evaluation of the kidneys as recommended in the report. The biopsy of the prostate was done on the same day as the IVP, and the report on the frozen section was, "Needle biopsy moderately well differentiated adenocarcinoma and prostatitis."

About a week later a bone scan was done and reported as negative. Renal ultrasonography was done at this time and there was no evidence of a solid mass in the kidney, but in the upper pole of the left kidney there was reported what was consistent with a "complex cyst." The report further read, "Differential diagnosis would include simple

cyst complicated by hemorrhage and infection. One cannot exclude carcinoma." No other abnormalities were reported.

After receiving this report, the urologist discussed with the patient both radiation and radical prostatectomy for his diagnosed cancer of the prostate. The patient agreed to the radical surgical procedure. About a month after he first presented to the primary care clinic, a CT of the abdomen was done. The only comment was "moderate hiatal hernia and possible gallstones." The record did not include a report on the examination of the permanent sections of the prostate biopsy.

It was about six weeks after this patient's initial visit to the clinic that he was admitted to the hospital for a radical prostatectomy. Again, there is documented a good discussion of the risks and benefits of the surgery except that in the record, no mention of impotence is recorded as a complication. He was taken to the operating room where the procedure was carried out without incident.

The following day the pathology report was attached to the chart. It reported that the prostate showed benign prostatic hypertrophy and the lymph nodes did not show any evidence of malignant disease. After the patient's discharge from the hospital, the biopsy of the prostate was reviewed and it was the consensus of all the pathologists in the department, including the one who originally reported the case, that the diagnosis was benign prostatic hypertrophy.

The patient was informed of the error at the first routine visit to the clinic after the surgery. He did well after surgery except that three months afterward, he claimed that he was impotent as a result of the operation.

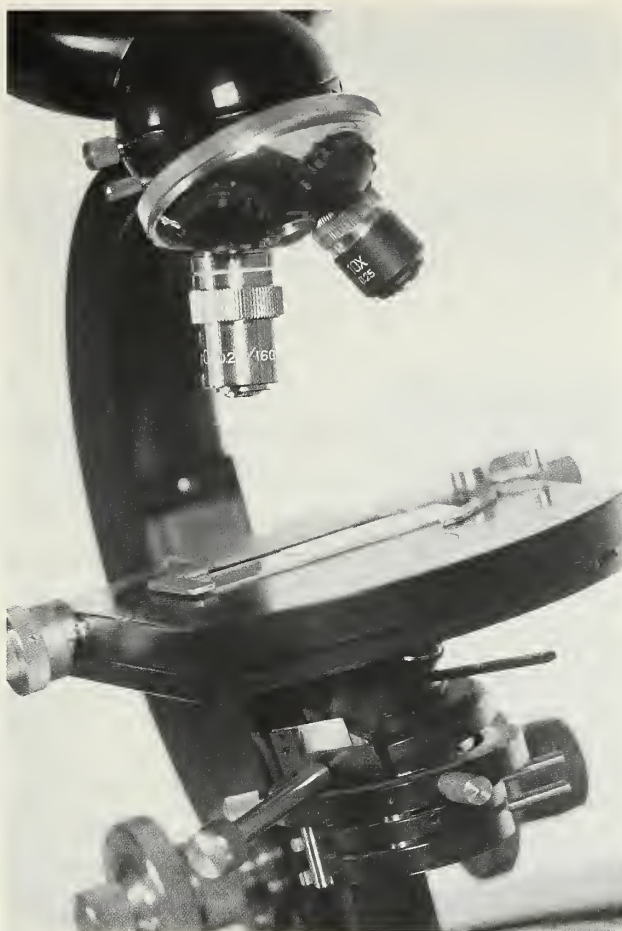
Six months later a lawsuit was filed charging the pathologist with negligence in the reporting of the frozen section from the prostate as cancerous and the urologist with a deviation from an acceptable standard of

care in that the informed consent did not warn him of possible impotence as a complication.

Loss Prevention Comments

The urologist in this case proceeded to act on the information he had, even though there appeared to be a "rush to judgment" in that the decision to proceed with the radical surgery was made, according to the record, less than a week after the patient reported to the clinic. It is documented that this decision was made before the workup was complete in that the possible complex cyst in the left kidney had not been thoroughly studied to rule out the possibility of malignancy in the kidney which would have been consistent with the original complaint of gross hematuria.

There was lack of good, informed consent in that the possibility of impotence was not a prominent part of the discussion. The physician said in deposition that he did, in fact, mention this complication but in the documentation of that discussion bleeding and infection only were made part of the record. I am sure that this 62-year-old man would have considered this possibility as one of the most important and threatening. In the consideration as to the management of this case, the prospect of a "swearing contest" between the urologist and the patient was prominent in the minds of the defense attorneys. Usually the patient wins such a contest. Both the clinician and the pathology department should have noted the absence of the permanent diagnosis. This kind of system failure is extremely common in cases where there is a bad result, and only in ret-



Should practicing physicians delay radical surgery until permanent tissue sections are examined? From the standpoint of loss prevention, the answer is yes. This practice would prevent most cases that turn on an error in tissue diagnosis made by a pathologist.

spect is the absence of the critical report discovered. This is especially damaging when the error is discovered, as it was in this case, by the plaintiff attorney in the examination of the medical record of the patient with the complaint.

The liability of the pathologist is present on its face. This physician was a junior member of the department and although, in retrospect, it would have been wise to ask for a more senior review of the tissue before the final report was issued, this was not

done. One must wonder why that in the departments of pathology it is not a policy for this to be done routinely and with all kinds of tissues that will be examined by the physician brought in as a new member of the team.

This kind of policy may exist but if it does, it was not followed in this case. The expectation is that one's own limitations are appreciated and are taken into account by the physician in any field of practice so that errors are prevented. This physician apparently felt secure in the examination of this frozen section but when the re-examination occurred, was willing to agree that the original reading had been an error.

Should practicing physicians delay radical surgery until permanent tissue sections are examined? From the standpoint of loss prevention, the answer is yes. This practice would prevent most cases that turn on an error in tissue diagnosis made by a pathologist. There would have been ample time in this case to do just that. It is now consensus that the prognosis of the patient is probably never significantly harmed by the practice of waiting for the permanent sections. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the August 1998 issue of Tennessee Medicine. It is reprinted with permission.

Christopher Hays Pope, MD



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ACR, ASCO

Honors/Awards: Outstanding Microbiology Graduate
1988, Phi Kappa Phi, Alpha Omega Alpha

Personal Information:

Date and place of birth: July 27, 1966, Lexington, Ky.

Hobbies: Weightlifting, scuba diving, travel, military
history, science fiction.

Dr. Christopher Pope says his sixth-grade teacher, Mrs. O'Connell, read "The Hobbit" to her class and that's all it took to spark an interest in reading and learning for the future radiation oncologist.

According to a profile he provided to *The Journal*, Dr. Pope is proud to have completed his board certification. If he weren't an oncologist, Dr. Pope says he would opt for a career as a scuba instructor, which jibes with his choice of favorite vacation spots — the Fiji Islands. Besides scuba, during his time away from CARTI, Dr. Pope also enjoys traveling, military history, weightlifting and science fiction.

Despite his self-confessed worst habit of oversleeping, Dr. Pope gives himself a pat on the back for not

procrastinating. He's also the proud owner of an 18th century Japanese sword and hopes to eventually set foot on all seven continents.

The single doctor says his favorite junk food is pizza, and he recently completed reading "Napoleon" by David Chandler.

Dr. Pope, who says he looked up to James Bond when he was a child, first earned a paycheck mowing yards. That first job, by the way, also is listed as his choice for worst job.

He says the single word that sums him up best is "funny." However, Dr. Pope sometimes loses his sense of humor when dealing with automated voice menus on telephone systems.

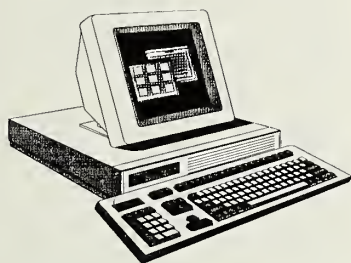
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HONORED

Dr. Heaton Named Chairman of Cancer Liaison Program

Dr. Keith M. Heaton of Little Rock is the new chairman of the Arkansas Cancer Liaison Program, part of the American College of Surgeons Commission on Cancer.

Dr. Heaton is one of more than 1,800 volunteer cancer liaison physicians who lead the Approvals Program and other Commission on Cancer endeavors. As state chairman, Dr. Heaton will help choose and lead cancer liaison physicians as local cancer programs are established.

Brummett Chosen to Lead Pulaski Medical Society

Carolyn Brummett is the latest executive director of the Pulaski County Medical Society. She succeeds Fred Reddoch.

Brummett has more than 25 years of experience in communications, community development, media and management. She is founder of Brummett Consulting, LLC, which specializes in health care communications and public relations.

Booneville Surgeon Honored for Work With Army

Dr. Sahibzada A. Ahmed of Booneville received a commendation from the U.S. Army for his laparoscopic surgery work at Fort Hood in Killeen, Texas.

Ahmed made three trips from June 1997 through April 1999 to Fort Hood to guide surgeons in laparoscopic surgery, which is needed to repair hiatal hernias.

Dr. Pappas Receives Caduceus Club Award

The Arkansas Caduceus Club presented Dr. James J. Pappas of Little Rock with the Distinguished Alumnus Award from the College of Medicine at the University of Arkansas for Medical Sciences. The award is for "exemplary dedication to patients, family and community and commitment of the support of medical education."

OBITUARY

Dr. Guy P. Shrigley

Dr. Guy P. Shrigley, 84, of Clarksville died Aug. 14, 1999.

Dr. Shrigley practiced medicine in Clarksville for 42 years before retiring in 1982. He graduated from the University of Arkansas School of Medicine in 1939 and completed an internship at Hillcrest Hospital in Tulsa. He received the Bronze Star for service in Europe during World War II. He was director of the Arkansas State Bank for 18 years.

He is survived by his wife, Diva, his son and two grandchildren.

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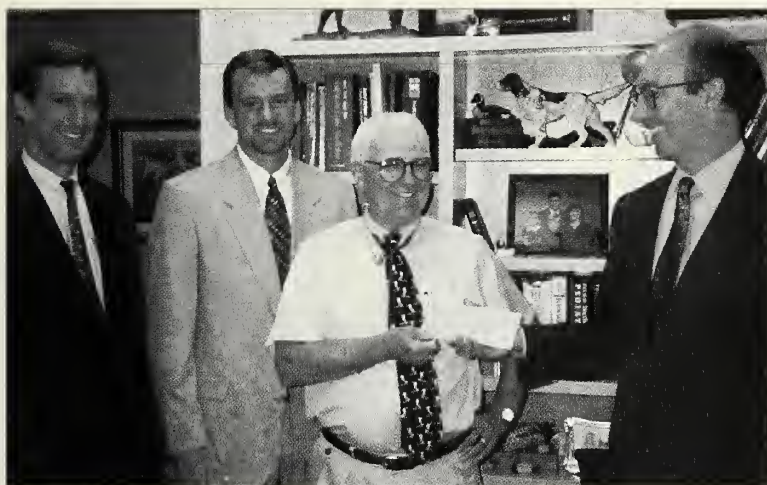
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AMF Receives Donation

Left: Steve Williams (right), president of the State Volunteer Mutual Insurance Co., hands a \$15,000 donation to Dr. Joe Martindale, medical director of the Arkansas Medical Foundation, with Randy Meador (left) and Thad DeHart of SVMIC. SVMIC is a long-time contributor to the Physicians Health Program in Arkansas.

AMA Alliance Meeting in Chicago

Bottom Left: Mrs. Gail Young, president of the Arkansas Medical Society Alliance; Mrs. Cynthia Weber, president-elect, and Mrs. Barbara Moody, past president of the Alliance, at the American Medical Association Alliance meeting in Chicago.

Bottom Right: AMS delegates, their spouses and AMS staff take time out from meetings at the AMA Annual Meeting in Chicago.



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For information about submitting an article to *The Journal of the Arkansas Medical Society*, see *information for Authors* on the last page of this issue or call Managing Editor at 501-224-8967 or 1-800-542-1058.

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The AMS Membership Directory

A quick and easy guide to AMS physician members, the directory provides addresses, phone and fax numbers, specialties and E-mail addresses. Plus other health related information. The directories are printed each year in late July.

The directories are \$50 each. With a purchase of 2 to 10, \$45 each; 11 or more, \$35 each. (Note: All AMS members receive one free directory through the mail immediately after publication in August of each year.)

The AMS's Physician's Legal Guide

A compilation of state and federal laws affecting the practice of medicine in Arkansas, this guide is 170 pages on topics such as medical records, patient abandonment, medical board regulations, Antitrust Law, Workers' Compensation, & much more. The List Price is \$100.00. **AMS Member Price is \$70.00.**

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For more information, call AMS at 501-224-8967.

**Oct. 8-9, 22-23,
Nov. 12-13**
**American College
of Managed Care
Medicine**

"Succeeding with Managed Care: Solutions I & II" will be held in Baltimore, Atlanta and Dallas. The series leads to board certification in managed care medicine. Contact Laura Bousquet, (804) 527-1905, fax (804) 747-5316 or e-mail lbousquet@aamcn.org. The web sit is www.aamcn.org.

Oct. 15-16
**Medical Director's Fall
Symposium of the
National Association
of Managed Care
Physicians**

Earn 12 CME hours at the Sheraton National Hotel-Ar-

lington (Va.). E-mail is lbousquet@namcp.com. The web site is www.namcp.com.

Oct. 25-26
**Fall Forum of the
American Association
of Integrated
Healthcare Delivery
Systems**

"Re-engineering IPAs, PHOs and MSOs for the Future" is the focus at the Flamingo Hilton in Las Vegas. Worth 10 CME hours. Call Laura Bousquet, (804) 527-1905, fax (804) 747-5316 or e-mail lbousquet@aahids.org for details. See the web site at www.aahids.org.

CALENDAR

Nov. 5-6
**Fall Conference of the
National Association
of Managed Care
Physicians**

"Critical Success Factors for the 21st Century Physician Practice" is the topic at the Sheraton National Hotel-Arlington (Va.). Earn 10 and a half CME hours. Contact Laura Bousquet, (804) 527-1905, fax (804) 747-5316 or e-mail lbousquet@namcp.com. The web site is www.namcp.com.

Nov. 16-17
**"Mapping Your Way
Through the Medicare
Maze"**

These workshops are set

for 1:30 p.m.-4:30 p.m. Nov. 16 at Farmers & Merchants Bank in Stuttgart and 9 a.m.-noon and 1 p.m.-4 p.m. Nov. 17 at the Southeast Area Agency on Aging in Pine Bluff. Call (800) 272-5528, ext. 3, to register.

Dec. 9-11
**National Rural Health
Association's Rural
Minority Health Con-
ference**

The theme will be "Community Voices Calling Us to Action" at the Hyatt Regency Tech Center in Denver. Call (816) 756-3140, fax (816) 756-3144 or e-mail mail@NRHArural.org for details. The web site is www.NRHArural.org.



Clockwise (L-R): Bill Smith, Keith McCullough, Stan Russ, Stephen Chaffin and Jim Strawn.

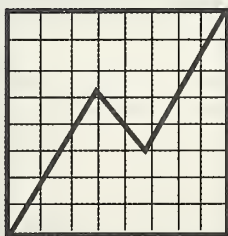
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PS Form 3526, September 1998 (Reverse)

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Photo: A.C. Haralson, Arkansas Department of Parks & Tourism

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The park sports a lodge with a history that begins with the Kansas City, Pittsburg and Gulf Railroad. The first lodge was built by the railroad company (which was backed by Dutch interests) in 1897 for its passengers. The resort was named for Holland's Queen Wilhelmina. The current lodge, with 38 rooms, was built in 1973 after fire destroyed the original structure.

Besides views, the comfortable lodge and fine dining, the park offers 40 campsites, a miniature railroad, an animal park, miniature golf course, a small store and laundry facilities. It's handy for hikers since the Ouachita National Recreation Trail passes through the park.

Queen Wilhelmina State Park, along the Talimena Scenic Drive, is on state Highway 88, 13 miles northwest of Mena in Polk County. Call the park at (501) 394-2863 or call (800) 264-2477 to make reservations at the lodge. The address is 3877 Highway 88 West, Mena 71953. The web site is www.1800natural.com/.

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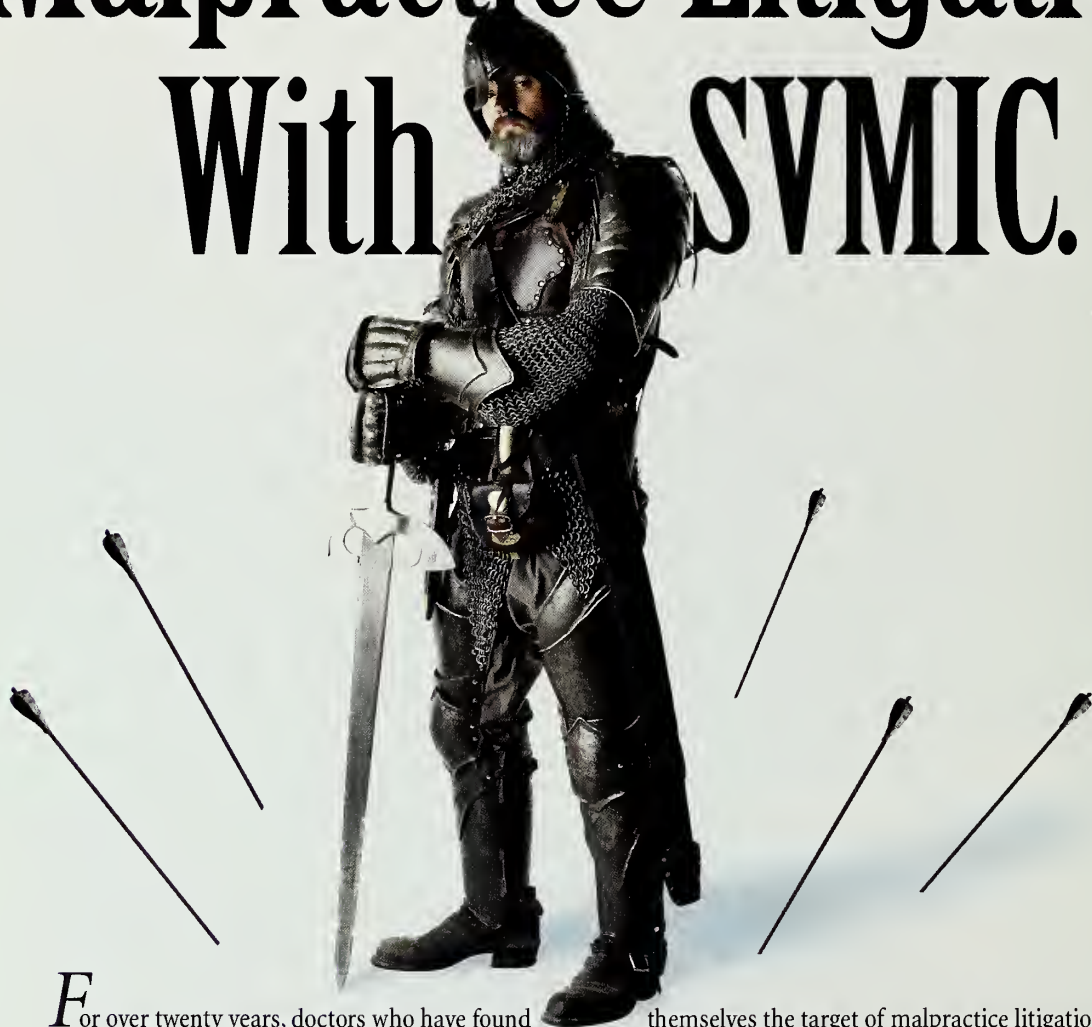
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A black and white photograph of a doctor's office. On the left, a white lab coat hangs on a mannequin. In the center, a vintage sewing machine sits on a wooden table. To the right, a wooden chair is visible. The background features a framed picture of a group of people on the wall and a patterned rug on the floor.

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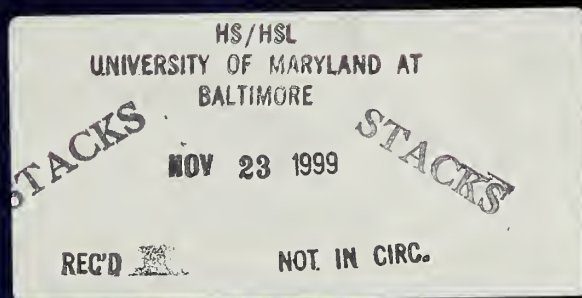
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THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Vol. 96 No. 6

November 1999



Special Report: **Settling Up**

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For Tobacco Suit Dollars

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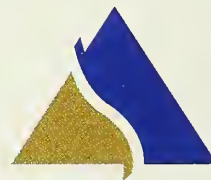
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THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

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207 Tobacco Money on the Way

Arkansas is beginning the process to decide how to spend money from a nationwide tobacco lawsuit settlement; the AMS has a plan that would fight nicotine addiction.

210 A Whole New Ballgame

After 25 years in practice, Dr. Carlton Chambers, secretary of the Arkansas Medical Society, brings his life experience as an otolaryngologist to academia at the University of Arkansas for Medical Sciences.

216 Fighting Back

Due to the increasing resistance rates among commonly encountered bacteria, it's imperative physicians re-examine their prescription writing habits.

225 Interpreting the Law

According to the Americans with Disabilities Act, doctors must provide "effective communication" to those with disabilities. But does that mean doctor's offices have to provide sign language interpreters if a deaf person requests it?

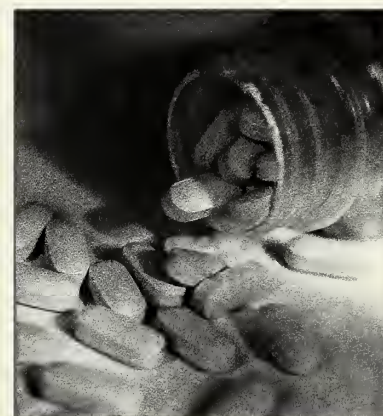
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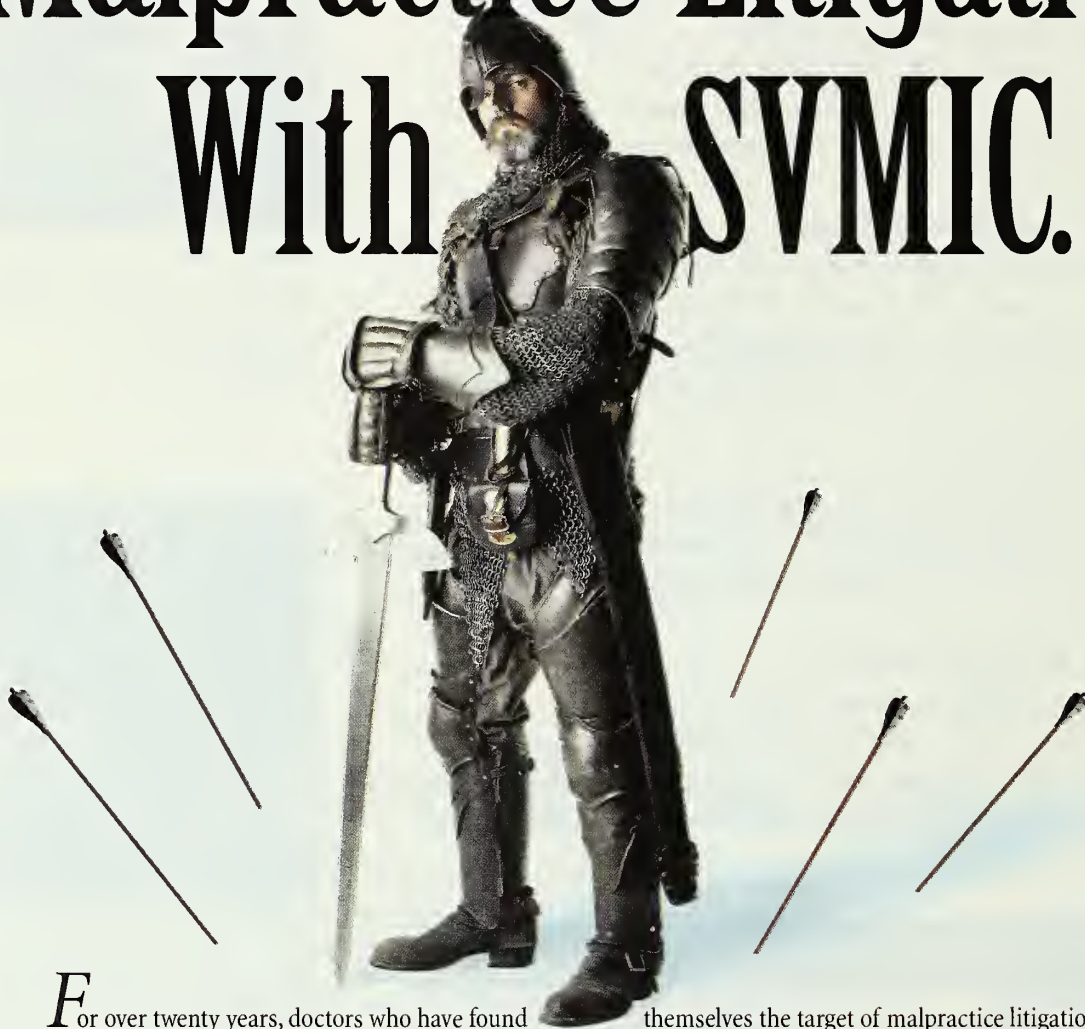


Arkansas' share of the 1998 settlement between states and the tobacco industry amounts to about \$1.62 billion over 25 years.
— page 207



In the United States alone, more than 20% of all antibiotic prescriptions are written for illnesses that are largely viral in etiology.
— page 216

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COMMENTARY

Advances Come at a High Price

JERRY KENDALL, MD

I have just reread Dr. Lloyd Langston's excellent inaugural address as published in the June 1999 issue of *The Journal*. It put me in a reflective mood, and I reminisced back to the time I entered medical school in 1965, two years after Dr. Langston. It was that year that Medicare first came on the scene, and I can remember several doctors who had come back from active practice to do residencies in a specialty they hoped would be more immune to the socialization of medicine — which they were sure was on the way. As a freshman medical student, I didn't worry about those things because all I wanted to do was learn to be a doctor and care for patients. The financial rewards of practice didn't concern me at all.

My father who, like Mark Twain said of his father, gets smarter the older I become, pressed me throughout college to take some general business courses. He felt that no matter what field one went into, he needed a basic understanding of business. That did not interest me at all. I was on the path of becoming a doctor, and I felt that if I did a good job of that, the financial part would take care of itself. I never imagined at that time that I would have to be concerned with office efficiency and overhead, much less with the more complex areas of insurance billing and proper coding. Medical school prepared me superbly for diagnosis and treatment but left me completely bereft in the areas of operating a business.

As it turned out, Medicare was financially, the golden egg of medicine for a number of years. I was fortunate to have practiced during this time and did well despite my ignorance in the administrative arena. Then, in the late 1980s and early 1990s, the Health Care Finance Administration began to creep into the picture and before long became a household word in any discussion of medical practice. Following closely on the heels of HCFA came health maintenance organizations and insurance companies that monitored my every decision.

I became immersed in DRGs, E and M codes, COBRA regulations and formulary restrictions. This was not medicine. This was not what I wanted to do or was trained to do. Even the business background that my father had argued for would not have helped me with this.

When I was a senior medical student, beta-blockers and Lasix were the latest in the drug armamentarium. CAT scans and MRI equipment were still on the drawing board, and coronary artery grafting was in its infancy. Since that time there have been remarkable advances in every area of medicine. Today because of the advances in medicine, people live much longer, fuller lives. And we have only scratched the surface of what can be accomplished in the new millennium. But this has come at a price, and the future of medicine hangs in the balance.

Will the next generation of students want to enter a field where they are threatened with exorbitant fines and gun-carrying federal agents poised to arrest them for a simple mistake made by their billing clerk? Will they tolerate the presence of insurance companies directing their decisions on hospitalization and choice of drugs? Will they be willing to work under the threat of lawyers ready to pounce on them because of an undesirable outcome? The answer to all these questions is yes. Because there will always be those who want to learn about the marvels of the human body and receive their compensation in the pleasure of knowing they made a difference in a fellow human's life. ■

Dr. Kendall is a family practitioner at Ouachita Valley Family Clinic in Camden. He is a member of the editorial board for The Journal.

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Workers' Compensation Commission Develops New Fee Schedule

By DAVID WROTEN

By the time this issue of *The Journal* arrives, Arkansas should have a new workers' compensation fee schedule. This has been a priority for the Arkansas Medical Society.

In 1987, the Arkansas General Assembly adopted legislation requiring the Arkansas Workers' Compensation Commission to develop a medical fee schedule for work-related injuries. In 1992, the Commission asked the AMS for guidance in developing a physician fee schedule. At that time the AMS, the Arkansas Hospital Association and the Arkansas State Chamber of Commerce joined together to develop physician and hospital schedules that became known as "Rule 30." Contrary to the agreement with the State Chamber, there has been no increase in the fee schedule since 1994, and the current physician schedule has not kept pace with changes in CPT coding.

The AMS has been working since mid-summer with the Arkansas Workers' Compensation Commission to develop a new fee schedule. This work has not been nearly as easy as it was in 1992. Back then, there was a single, generally accepted basis for establishing fees — the Arkansas Blue Cross & Blue Shield fee schedule. Between managed care and ABCBS's adoption of the Medicare Resource Based Relative Value System last year, fee schedules in Arkansas now vary from versions of the old ABCBS schedule to multiples of Medicare (i.e. 150% of Medicare). In 1992, the methodology was quite simple and negotiations centered on the level of fees. Now, the most difficult negotiations surround developing a methodology that is easy to implement, easy to update (both for inflation and changes to CPT) and is acceptable to physicians as well as payors.

What has come from the negotiations is the realization that the best methodology for implementing a fee schedule and keeping it current is Medicare's RBRVS. Note that we are talking "methodology" not Medicare fees. The RBRVS is widely published and updated annually for CPT changes. Switching to an RBRVS based schedule also has a down side. When ABCBS switched to RBRVS last year, several medical specialties, namely diagnostic radiology, orthopedic surgery and neurosurgery, saw 20% to 30% decreases in their Blue Cross revenues. Those same specialties account for the bulk of the care provided in workers' compensation.

The challenge then becomes to adopt RBRVS in a manner that mitigates the impact on any one specialty. What is being proposed to accomplish this is a fee schedule with separate conversion factors for each major category of CPT — medicine, surgery, radiology and pathology. While this is not a perfect solution, it is certainly better than a single conversion factor. Annually, the Commission will only need to review the conversion factors rather than the entire fee schedule, and as mentioned above, RBRVS already updates the relative values each year for changes in CPT.

The conversion factors being considered were developed to provide an increase of 10% to 15% over the current Workers' Compensation Fee Schedule in recognition that there has been no adjustment since 1994.

The role of the Arkansas Medical Society in this process cannot be overstated. When the original 1992 fee schedule was proposed without input from the AMS, the Commission's "consultant" had recommended the adoption of Medicare, the fees, not the methodology. Since that time, the Commission has looked to the AMS for advice and expertise in ensuring that any physician fee schedule be acceptable to physicians. ■

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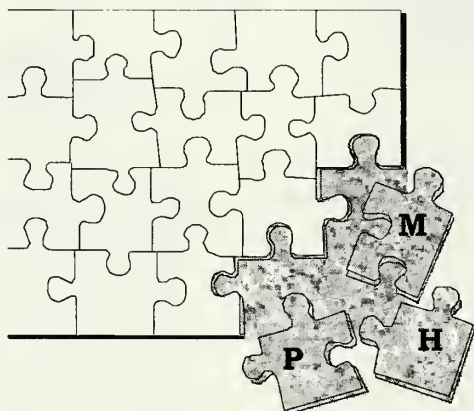
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DAYS GONE BY

Case of Gallstones Simulates Appendicitis

Mrs. J.A.M., a widow, 35, of slender build, dark complexion and dark hair.

As I was passing her residence on Oct. 1, 1896, I was called in to prescribe for her on account of pain in right lumbo-inguinal region, together with some nausea.

I found tenderness and some tumefaction at a point midway between the umbilicus and the right anterior superior spinous process of the ileum. I diagnosed appendicitis, prognosticated rather slow recovery and the treatment prescribed was external application of tincture of iodine over painful point; and, internally, quinia, phenacetioe and leptandrin.

On Oct. 7, I found at McBurney's point a tumor, biscuit-shaped and about two inches in diameter.

On Oct. 12, the tumor had grown somewhat. At this time I vainly insisted upon an operation for appendicitis or caecal abscess.

On Oct. 20, the tumor had grown to probably four inches in diameter and showed some softening in the middle. I wished to open the abscess, dry it out with gauze and pack it with the same. As the patient was averse to all surgical interference I consented to her request.

On Nov. 1, she stated to me that she had continued the poulticing for several days, and that there was discharge through the skin at the soft spot of the tumor, of a viscid, yellowish fluid, which still continued. After the appearance of this discharge, she used a simple dressing of suet; the bowels were still undisturbed. I told the patient this cavity should be cleansed and packed. She would not submit to it.

On Dec. 1, patient found, to her great astonishment, a gravel in the dressing, and subsequently, other biliary calculi passed through this opening.

On the subject of operation for appendicitis, I am of the opinion that not every case necessitates operative interference, any more than every case of hysteria necessitates treatment of the uterus or its appendages. ■

Reprinted from the "Proceedings of the 24th AMS Annual Session," May 1899.

I N + T H E + N E W S



Access Foundation Provides Free Care

The Arkansas Health Care Access Foundation provided free medical service to 16,056 medically indigent persons as of August 1999. This program has 1,935 volunteer health professionals, including doctors, dentists, hospitals, home health agencies and pharmacists. These providers offer care in 69 of the state's 75 counties.

The organization began in 1989 by the Arkansas Medical Society to provide free medical care to low-income Arkansans who are uninsured.

For more information, call (800) 950-8233 or (501) 221-3033 in Little Rock.



Report Reveals Data on Treating Depression

"Treatment of Depression — Newer Pharmacotherapies," a study from the Agency for Health Care Policy and Research, provides an evaluation of the benefits and adverse effects of new pharmacotherapies and herbal treatments for depressive disorders in adults

and children. The report includes data on 29 antidepressants and three herbal remedies.

The newer antidepressants studied clearly were effective treatments for major depression and dysthymia, although they were shown to have similar efficacy and total dropout rates when compared with older antidepressants.

The full report is available by calling (800) 358-9295 and asking for Evidence Report/Technology Assessment No. 7 or by checking AHCPR's web site, www.ahcpr.gov.



Cancer Rates Falling, Treatments Improving

A recent issue of the *Rural Clinician Quarterly*, the newsletter of the National Rural Health Association, is dedicated to the falling cancer rates and methods patients and doctors can use to discover and treat the diseases.

The newsletter cites data from the American Cancer Society, the American Lung Association and other groups. Some of the data was taken from the American Cancer Society's "Cancer Risk Report — 1999." More information is available at www.healthfinder.gov.

The NRHA's web site is www.nrharural.org.



Nominations for Award Deadline Is Nov. 15

Nominations for the Joretta Wilkins Breast Cancer Award will be accepted until Nov. 15.

The award is for a person or organization that has provided screening, prevention, diagnosis and treatment of breast cancer; promoted breast cancer education; or furthered breast cancer research during 1999. Nominees must be residents of Arkansas; organizations must have a physical presence in the state.

Send nominee's name, address, phone number, a 300-word essay and three letters of reference to Breast-Care, c/o Alison Melson, 225 E. Markham St., Suite 450, Little Rock, AR 72201. Call (501) 375-3003, ext. 179, for details.



Heart Association Seeks Patient Compliance

The American Heart Association has begun an effort to overcome a problem many doctors have known

about for years: patients' lack of following treatment recommendations.

According to data cited by the AHA, more than half of Americans with chronic diseases do not follow their physicians' medication and lifestyle guidance, 80 percent don't exercise adequately and half of all prescriptions are taken improperly. The estimated cost of the lack of compliance is about \$100 billion.

To get its point across, the AHA has put together the Physician's Compliance Tool Kit and a booklet, "Knock Out America's Hidden Health Threat." Both are available by faxing a request to (214) 706-5233 or by calling (800) 242-8721 (AHA-USA1).



Group Provides History of Health Sciences

The History of Medicine Associates is an organization created to stimulate interest in the resources and facilities of the Historical Research Center of the UAMS Library. Membership in the association is open to anyone who is interested in the history of the health sciences. For membership information, call (501) 686-6733 or e-mail mannedwinawalls@exchange.uams.edu. ■

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Tobacco Settlement Dollars Should Reach Root of Problem

ARKANSAS' SHARE OF THE 1998 SETTLEMENT BETWEEN STATES AND THE TOBACCO INDUSTRY AMOUNTS TO ABOUT \$1.62 BILLION OVER 25 YEARS. HOW THAT MONEY WILL BE SPENT COULD BE PARTIALLY DECIDED BY THE HOUSE TOBACCO SETTLEMENT TASK FORCE WHEN IT HEARS FROM HEALTH EXPERTS AND OTHERS DURING MEETINGS NOV. 2-4.

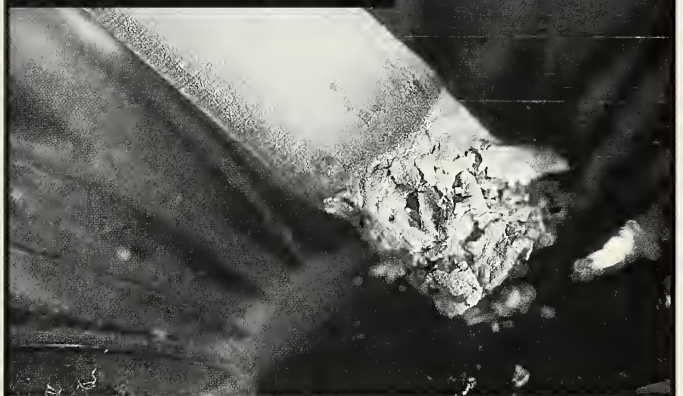
The Arkansas Medical Society has a clear plan for using the money to fight tobacco use and the effects of tobacco abuse, said Dr. William N. Jones, a Little Rock dermatologist and a past president of the AMS. "Logically, [the settlement money] should be spent on tobacco control, which is what it's all about," Dr. Jones said. "Every single dollar that is spent on anything other than fighting tobacco's use and controlling of issues is a dollar the tobacco companies are going to be happy about because it isn't spent against their product."

About \$246 billion is scheduled to begin flowing to states in July 2000 if 80 percent of the states involved agree to the settlement by then. Arkansas' first payment will be \$19.9 million, and the state will receive between \$53.1 million and \$69.5 million annually after that.

Other states will go through a similar process trying to decide how the money should be spent. The Arkansas task force hopes to outline and explain to legislators the financial possibilities of several plans, rather than decide which one will be adopted. Dr. Jones, one of three Arkansas delegates to the American Medical Association annual meeting last June, has heard about some of the proposals in other states.

"I learned that states are spending money on infrastructure, buildings, bridges, reduction of taxes, scholarships for higher education and a jillion other things and only a smattering of it is going for health care issues," Dr. Jones said. "I have contended from the very beginning that every penny of this money ought to be spent on health care issues and the priority ought to be for tobacco control programs that involve preventing youth from starting and doing the things necessary to stop it before it starts."

CDC COST ESTIMATES



The Office on Smoking and Health at the Centers for Disease Control and Prevention estimates the annual cost of a comprehensive tobacco prevention program for Arkansas to be between \$17.9 million and \$46.4 million.

Here's the breakdown (in millions of dollars, except per capita figures):

Community Programs to Reduce Tobacco Use	\$2.6-\$6.2
Chronic Disease Programs	\$2.8-\$4.2
School Programs	\$2.4-\$3.7
Enforcement	\$1.2-\$2.3
Statewide Programs	\$1.0-\$2.5
Counter-Marketing	\$2.5-\$7.6
Cessation Programs	\$2.9-\$13.9
Surveillance and Evaluation	\$1.6-\$4.0
Administration and Management	\$0.8-\$2.0
TOTAL ANNUAL COST	\$17.9-\$46.4
Per Capita Funding Range	\$7.10-\$18.41

VARYING PROPOSALS

Dr. Harry P. Ward, chancellor of the University of Arkansas for Medical Sciences, and Dr. Fay Boozman, director of the Arkansas Department of Health, were asked by Gov. Mike Huckabee to create a master plan for the funds. Called "The Better Health Plan," its aim is to divide the settlement money three ways and spend it on medical education, prevention and research. The plan would establish a trust that would begin with \$35 million — the first two annual payments to the state. Annual appropriations would amount to \$28 million for smoking

prevention, \$17 million for medical education and \$17 million for research (Arkansas Biosciences Institute).

"We are fortunate in Arkansas that we have the leadership of the Senate and the House and the governor all saying the money would be spent on health," Dr. Jones said. "We're the only state I know of where the leadership has said, unequivocally: health care issues."

Although Dr. Jones gives a nod to the State's intentions, he believes the plan takes the wrong approach.

"The Centers for Disease Control has a document they call the 'Best Practices for Comprehensive Tobacco Control Program,'" Dr. Jones said. "That came about by seeing what has worked in California and Massachusetts and New Jersey where they've taken the best part of everybody else's ideas about how to control tobacco use. They've published, for all 50 states, what the CDC estimates, according to the population of each individual state, how much money from the tobacco settlement would be necessarily spent to control or help control and prevent the use of tobacco."

According to CDC figures, the Arkansas cost would run from \$18 million to \$45 million each year.

"Arkansas has one of the worst records from the standpoint of health," Dr. Jones said. "Does it make any sense at all that we would spend the minimum number of \$18 million to \$20 million of this tobacco settlement money per year on a control program when we've got the worst statistics? We ought to be spending considerably more than that. I don't know what that number should be and that's to be worked out."

A TOBACCO ISSUE

The AMS is opposed to any dollar of the tobacco settlement going for research or being spent on uncompensated care.

"This is a tobacco issue," Dr. Jones says. "It was a tobacco settlement. It was because of what tobacco has done to health. We don't need any more basic

science research on nicotine or on tar or on cigarettes or on the social impact. It's already been done."

Dr. Jones said the most important aspect of tobacco control is youth access, including laws and enforcement.

"Arkansas has had some laws for youth access for some time now, but there's no money set aside for enforcement," Dr. Jones said. "In the time it takes you to fill a Suburban's gas tank, there's about three different groups of kids who have gone in to buy cigarettes."

Tobacco cessation is important, too, as are counter-advertising and environmental tobacco smoke regulation.

"We ought to have whatever it takes

[the money] in a trust or what have you," Dr. Jones said. "It looks like, politically, some form of that is going to take place. It's my opinion that it would be better to spend the money as it comes in and have it for as long as it lasts than it would be to risk losing significant sums of it through that method. By doing it that way you've got every legislator that comes here after to be able to divert it any way they want to."

"We need legislation that commits it to health and outlines how it's going to be done."

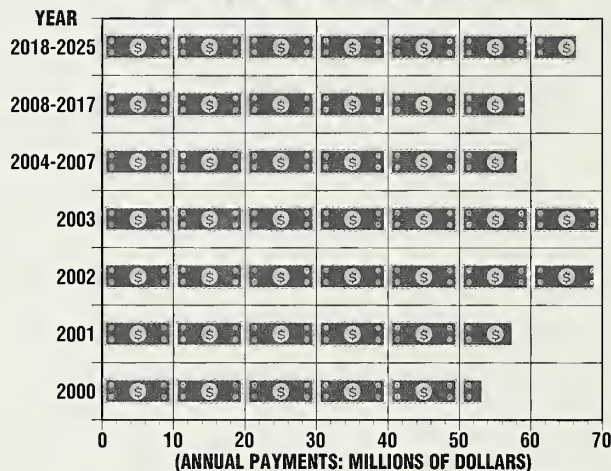
Dr. Jones believes that, with the help of the health department, the settlement opens an opportunity for Arkansas to fight its tobacco-related problems. He also points out there are many worthy causes represented by groups that would like a chunk of the money. But he also believes that the health of the whole carries more weight.

"If I had my way we'd spend every single dollar on tobacco control," Dr. Jones says. "I'm sure we could find a way to do it, and it would be an effective program."

Of course, the federal government also is suing because it has been supplementing Medicaid for years. Conceivably, the states may never receive money from the settlement.

"Wouldn't that be wonderful," Dr. Jones said. "It would mean the tobacco industry is on its knees, and that's our whole purpose: Get the damn stuff out of our society."

Arkansas' Share of Tobacco Settlement



Graphic: Dianna Noe

to help people who sincerely want to quit smoking through counseling and pharmacological use of drugs," he said.

TAKING A STAND

To get the idea across, the AMS plans to have experts from the CDC and the AMA address legislators. The experts wouldn't be lobbyists but would simply explain what tobacco control programs are and how much they cost.

Besides the choices of which endeavors should be funded, there are financial decisions about how the money should be handled. The 20-member task force is exploring financial options, such as bonds and trusts.

"They've been discussing securitization where they would sell bonds or put

SUMMARY OF AMS POSITION

- The AMS believes the No. 1 spending priority for Arkansas' tobacco settlement should be fully funding the comprehensive tobacco control program developed by the Centers for Disease Control.
- The AMS believes that the Arkansas Department of Health is best positioned to implement the CDC program.
- The AMS believes that settlement funds should be utilized to secure federal matching Medicaid money to develop an adult program similar to ARKids First. ■

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Meet Our Members

Carlton L. Chambers III

BY JUDITH M. GALLMAN

Sometimes it's hard to know where to find Dr. Carlton L. Chambers III.

On any day Dr. Chambers, 60, an assistant professor in the department of otolaryngology at the University of Arkansas for Medical Sciences, could be in surgery in a University Hospital operating room, lecturing in a UAMS classroom, seeing patients at the UAMS head and neck surgery clinic or making rounds at the John L. McClellan Veteran's Administration Hospital. Or he could be delivering a seminar for the general public on two pet topics, sleep apnea and allergy research, or be huddling in an ad hoc committee meeting of the Arkansas Medical Society. He could be passing judgment on suitable continuing education credits or helping determine whether a hospital meets certification requirements.

Then again, Dr. Chambers might be out of the office and away from scholarly and physician duties, backpacking in the Colorado backcountry, doing a little fly fishing or flying his airplane from Harrison to Little Rock and beyond.

Dr. Chambers is a busy man, and he doesn't intend to slow down.

Unlike most physicians who follow academic pathways, Dr. Chambers has gained much of his knowledge from on-the-job training and continuing education. He spent 25 years in private practice in Harrison but now finds himself in the thick of academia. He gave up an active ear, nose and throat practice and signed on with the department about 14 months ago to lend his generalist perspective.

Time for a Change

"I enjoyed practicing immensely," Dr. Chambers says. "Most doctors in an academic setting desire to do so from the start and did decide [to do so] early in their [pathway]."

Disillusionment with managed care and what he perceived as its adverse ef-

fects on patient care were factors in Dr. Chambers' decision to leave private practice. Joining a residency training program appealed to him and intrigued him, so he accepted the university's invitation and joined the ranks of the state's top otolaryngologists whose subspecialties range from cancer to plastic surgery.

"The quality of medical students has increased dramatically in the last decade," Dr. Chambers says of his students, describing them as more interested and dedicated than their counterparts 15 years ago. Today's students are more "actively involved in learning," he says.

Dr. Chambers says he also made the move because he felt indebted to his school and department and wanted to contribute something to both and that he

embraced an opportunity to sharpen his medical skills.

Dr. Chambers speculated that his career path has made him a "broader individual" than a strictly academic physician. Because of his years of practical experience, he says, he can share practical advice with students about topics never taught in the classroom, including negotiating contracts with hospitals, making business and financial decisions and marketing.

Outside the Office

He's happy with his career decision, though his pace certainly hasn't slowed.

Dr. Chambers has gone from a 50-hour work week to a 62-hour work week.

He finds time for professional organizations, too, serving as the current secretary of the Arkansas Medical Society and a member of the long-

Dr. Chambers brings a generalist perspective to UAMS.

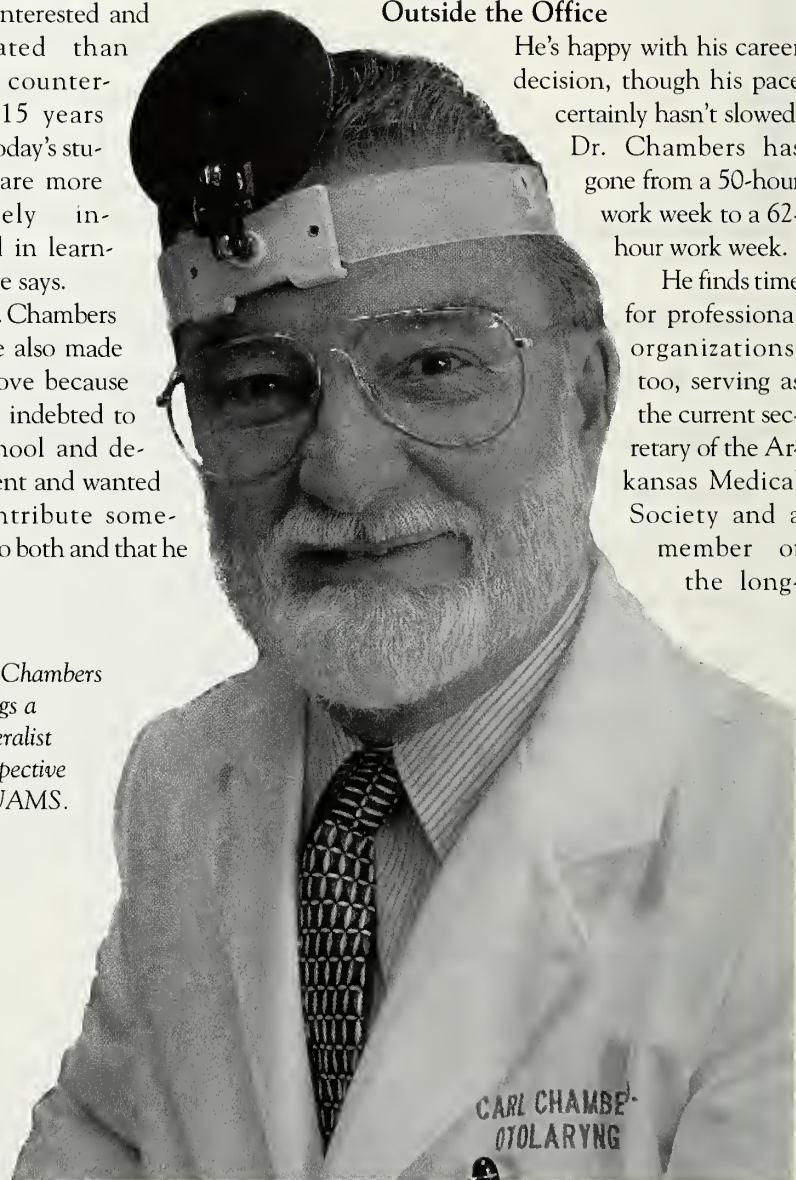


PHOTO: SPENCER TIREY

range planning committee, an ad hoc group appointed to study AMS. The committee is seeking ideas from members on changes or improvements. Dr. Chambers says he's keeping an open mind and wants colleagues to let the committee know their opinions.

"The Arkansas Medical Society has been a vital tool here for a century. . . . A lot of what we do is archaic and not needed any more," Dr. Chambers says, declining to be specific to prevent tainting the study process. Dr. Chambers says efforts going toward outdated or time-wasting practices must be redirected.

"I am a member of the AMS and the AMA because I believe that all medical doctors are, first, medical doctors and their specialty should come second and that the house of medicine is for the benefit of the patients," Dr. Chambers says. "The AMA and AMS [have] to hold together to provide a united voice for medical care. The AMS and AMA are the cornerstones [of medical care]."

"We gave up our youth," he says. "We literally deferred that boat, car [and]

children four to eight years longer than the other kids we graduated with to be medical doctors. We owe it to the profession to hold together."

Strong Partnership

Dr. Chambers is married to Dr. Sue Ross Chambers, a pediatrician with Arkansas Children's Hospital, who also teaches. The two met in medical school (literally over a cadaver, Dr. Chambers recalled). The couple shared offices in Harrison. Their home was 60 feet from the local emergency room and 120 feet from their office, Dr. Chambers says.

"That's how we did it," he says.

They maintain their primary residence in Harrison, spending weekends there. Air travel — Dr. Chambers has been a pilot for 18 years — cuts commuter time to a minimum. They are active in St. John's Episcopal Church, and Dr. Chambers serves on the church's long-range planning committee, sings in the choir and has organized a family five-piece brass band. The couple has four grown children (three boys and one girl, includ-

ing a pharmacist, a Broadway dancer, a business manager at an advertising firm and a doctoral candidate in English), plus grandchildren.

What's Next

Dr. Chambers, who has a long history of activity in medical issues, served as the president of the Boone County Medical Society for 12 years and helped form a legislative lobbying association, the Boone Docs. He also was the chief of staff at Boone County Hospital for four years.

He has no plans to retire and said he may turn to research. Dr. Chambers is particularly interested in ENT allergy medicine and obstructive sleep apnea. He is pushing to include an allergy sequence in the UAMS residents' training and has access to a new UAMS sleep lab as a research tool.

But Dr. Chambers plans to relax a bit along the way. For fun, he and his hiking partner (his brother-in-law) may stay in their own back yard and strike out soon on the Ozark Highlands Trail. ■

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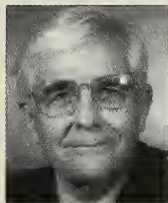
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Obesity, A Complicating Factor in this Diagnosis

J. KELLEY AVERY, MD

While the standard of care questions in this case could be debated, there can be no debate over the failure to put the facts together, which produced a delay in the appropriate evaluation of this patient and the diagnosis of a treatable condition.

A 37-year-old man who weighed almost 300 pounds went to one of the members of a primary care group complaining of fever, shortness of breath and a nonproductive cough. The physical examination was not remarkable except for the obesity and "slight expiratory wheezes" over the lung fields.

The WBC count was normal at 9,800/cu mm and no differential count was done. The treatment consisted of an injection of a steroid product, a broad-spectrum antibiotic and a theophylline preparation. Five days later the patient returned and saw a second member of the group with the presenting complaint of "no better," shortness of breath and cough continued. On this occasion he also complained of difficult breathing when lying down, requiring some pillows to elevate his head and shoulders. On this visit, the WBC count was reported to be 17,000/cu mm. Again no differential was done. The treatment previously given was to be continued, and again steroids were given by injection. He was asked to return a week later, but he returned early, stating that his chest was much better, but he had some cramping pain in his left calf. No examination of the chest or leg was documented. The impression was "myositis." He was given a prescription for a non-steroidal anti-inflammatory drug (NSAID) and advised to apply heat/cold compresses to the leg. He was not given a return date.

Three days later he returned, again complaining of pain and swelling in the left calf. There was some swelling and tenderness recorded by the doctor; the chest was said to be clear. The impression was again myositis, and another injection of steroids was given. He was told to return as needed.

Ten days after the previous visit, on a weekend, the patient's wife called the phy-

sician on call for the group and informed him that her husband had a recurrence of the "bronchitis" and had been short of breath on the slightest exertion for about three days. The call was made at 5:43 p.m. The physician on call insisted that the patient be brought to the emergency department of the local hospital for evaluation.

When the ambulance arrived at the patient's home at 6:26 p.m., the patient complained of not being able to breathe. With the paramedics in attendance at the home, the patient went into full arrest and was transported to the hospital with CPR in progress. He arrived at the nearest hospital and was pronounced dead on arrival.

An autopsy was done, with a pathologic diagnosis of pulmonary thromboembolism, popliteal thrombophlebitis, chronic thromboembolism in the lungs and right ventricular hypertrophy.

A lawsuit was filed within the required time, charging the primary care group and the physician who saw the patient on three of the last five visits with negligence for not having done a more thorough evaluation of the patient's complaints of wheezing and cough, particularly a chest X-ray and other pulmonary studies, which might have provided an accurate diagnosis and provided the basis for appropriate treatment.

Loss Prevention Comments

The patient was an obese muscular young man engaged in the moving business. He lifted heavy furniture and appliances in his work, and even with his obesity was considered to be in good health. In view of the autopsy findings, one wonders about previous bouts of "wheezing and shortness of breath." Almost certainly, all of the thromboemboli found in the lungs did not occur during the final two weeks of his life. The organization of the thrombi in the

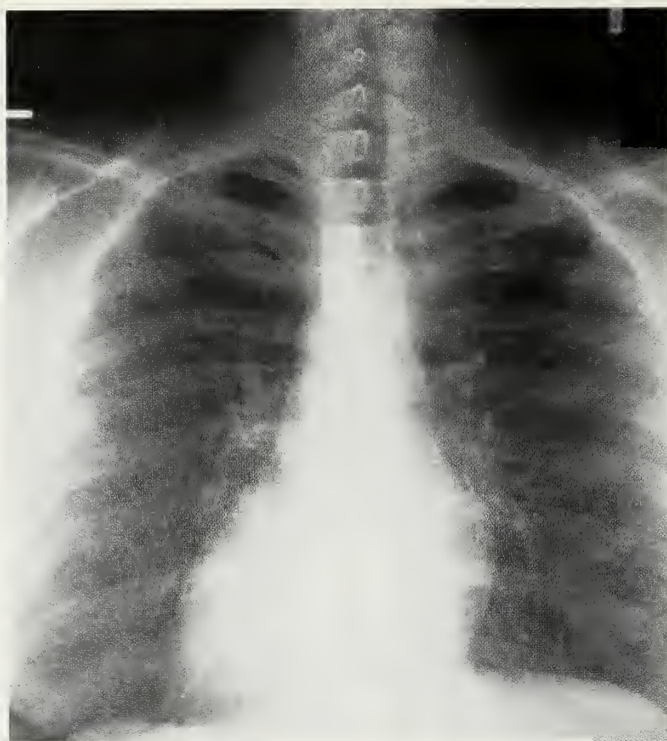
lungs and the right ventricular hypertrophy strongly point to a continuing problem. During this last illness, however, there were clues that make the diagnosis apparent in retrospect without the pathologic findings.

It seems that the complaints themselves should have triggered consideration of the diagnosis. One cannot criticize the initial impression of "bronchitis" or the treatment administered. The injectable steroids might raise the question of the standard of care, but within the context of that first encounter, probably would not be condemned.

On the second visit, the first to the offices of the group, the WBC count had increased from 9,000/cu mm to 17,000/cu mm. The temperature was not recorded, but the history of chest complaints was said to be "much better." The increase in the WBC count should have been seen as significant and led to more definitive studies of the chest. Steroids were again given even though the office had to send the patient to the emergency department of the hospital to get the injection.

Apparently the patient was concerned enough about the soreness, cramping and pain in the calf of the left leg that he came back to the physician's office in three days although he had been given an appointment for a week from the time of the previous visit. This early visit by an otherwise stoic patient should have caused the doctor to question whether or not there might be more going on than he had originally thought.

There is no recorded examination or measurement of the leg to compare with the unaffected extrem-



Again, steroids were given by injection. It is at this point that the correct diagnosis should have been strongly considered based on the available facts. Swelling, pain, elevated WBC count and tenderness in the leg were enough to suggest deep vein thrombosis in the calf as the site of emboli to the lungs as the cause of the illness.

ity. But medication and heat to the leg were prescribed for pain. The patient did come back for the appointment he had been given four days after the visit during which he complained about his leg. On this occasion, the record indicates "slight muscle tenderness" of the calf, but still no measurement of the leg was recorded. Chest findings had cleared. Again, steroids were given by injection. It is at this point that the correct diagnosis should have been strongly considered based on the available facts. Swelling, pain, elevated WBC count and tenderness in the leg were enough to suggest deep vein thrombosis in the calf as the site of emboli to the lungs as the cause of the illness.

The subsiding chest complaints would indicate that the previous insult to the pulmonary circulation had improved and was waiting for the next one.

Why was this not apparent to the attending physician? Could the orientation in this practice have been so focused on the current complaint that there was no thought of tying it into the entire picture of the present illness? This is a hazard in the practice of primary care medicine where the patient load is heavy and there is a need to respond to the complaints of many patients within the course of a day. Yet the value in this kind of practice lies in the opportunity to deal with the whole patient and his complaints over time.

While the standard of care questions in this case could be debated, there can be no debate over the failure to put the facts together, which produced a delay in the appropriate

evaluation of this patient and the diagnosis of a treatable condition. When liability is the issue in this kind of case, it becomes whatever a jury says it is.

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented. ■

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the September 1998 issue of Tennessee Medicine. It is reprinted with permission.

Influenza Vaccine Update

Influenza vaccine is the primary method for preventing influenza and its more severe complications.

The primary target groups for influenza vaccination includes persons 65 years and older; residents of nursing homes and other chronic-care facilities; adults and children who have chronic pulmonary or cardiovascular disorders (including asthma); adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies or immunosuppression (including immunosuppression caused by medications); children and teen-agers (6 months-18 years) who are receiving long-term aspirin therapy; women who will be in the second and third trimester of pregnancy during the influenza season; persons who can transmit influenza to those at high risk; persons infected with HIV; breastfeeding mothers; travelers; and any other persons who wish to reduce the likelihood of becoming ill with influenza. The vaccine can be administered to children as young as 6 months. The vaccine should be given starting in October and continued through March or whenever the flu season is over.



The vaccine should not be given to persons known to have anaphylactic hypersensitivity to eggs or other components of the influenza vaccine.

This season's vaccine will include: A/Beijing (HLNL), A/Sydney (H3N2) and B/Beijing (U.S. manufacturers will use

the antigenically equivalent B/Yamanashi virus instead).

Persons with questions concerning the influenza vaccine can contact the Arkansas Department of Health, Division of Communicable Disease/Immunizations at (501) 661-2169. ■

Reported Cases of Selected Diseases in Arkansas

Profile for August 1999 - The 3 month delay in the disease profile for a given month is designed to minimize any changes that may occur due to the effects of late reporting. The numbers in the table below reflect the actual disease onset date, if known, rather than the date the disease was reported.

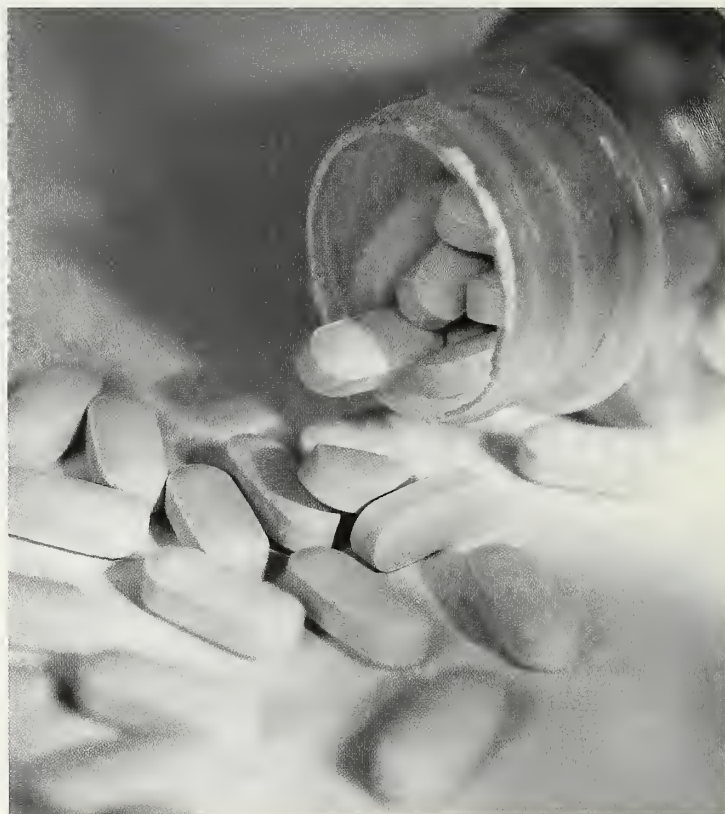
Disease Name	Total Reported Cases YTD 1999	Total Reported Cases YTD1998	Total Reported Cases YTD1997	Total Reported Cases 1998	Total Reported Cases 1997
Campylobacteriosis	121	120	119	179	175
Giardiasis	101	108	146	168	220
Salmonellosis	377	339	272	616	445
Shigellosis	61	138	157	211	273
Hepatitis A	39	72	172	82	223
Hepatitis B	35	85	67	115	106
Hepatitis C	5	2	4	10	5
Meningococcal Infections	31	26	26	31	38
Viral/Aseptic Meningitis	28	56	16	77	26
Ehrlichiosis	19	12	21	14	22
Lyme Disease	4	6	23	9	27
Rocky Mtn Spotted Fever	15	19	30	23	31
Tularemia	12	20	19	26	24
Measles	2	0	0	0	0
Mumps	0	9	1	13	3
Chlamydia	3945	2525	2041	4127	2554
Gonorrhea	2004	2669	3264	3962	4388
Syphilis	116	210	311	294	394
Pertussis	16	67	30	93	60
Tuberculosis	118	78	123	171	200

For a complete list of reportable diseases in Arkansas, call the Arkansas Department of Health, Division of Epidemiology, at (501) 661-2893 during normal business hours.

A Call for the Judicious Use of Antibiotics

RHONDA J. MERCHANT, MD
GORDON E. SCHUTZE, MD

In the United States alone, more than one-fifth of antibiotic prescriptions written are for viral illnesses. Due to the increasing resistance rates among commonly encountered bacteria, it is imperative that physicians re-examine their prescription writing habits. Physician and patient re-education, better use of diagnostic testing, the use of narrow spectrum antibiotic agents and shorter course therapy are essential for this to occur. The future health of Arkansas residents is dependent upon changes being implemented before it is too late.



There is a strong association between the magnitude of antibiotic use and the emergence and spread of antibiotic resistant isolates in our country today. In this era of emerging microbial resistance, the judicious use of these agents has never been more imperative. In the United States alone, more than 20% of all antibiotic prescriptions are written for illnesses which are largely viral in etiology.

The increasing resistance of bacterial organisms, such as *Streptococcus pneumoniae*, is a direct result of this antibiotic overuse. Although the current problems with resistant organisms can be blamed in a large part on the prescription practices of the physician, this is not the only factor responsible for our current dilemma. Fortunately, there is a new acknowledgment that many illnesses clinicians encounter on a daily basis are self-limited. For those infections which do require antibiotics, there are now data available on shorter duration of therapy that have been demonstrated to be just as effective as the more traditional duration of 10 to 14 days. Clinicians need to become aware of the problems that arise from indiscriminate antibiotic use and understand that the health of the public is being adversely affected by our current practices. Changing physicians' and patients' attitudes are required in order to attack this problem.

Overuse of Antibiotics

Results of formative research in the United States suggest four major factors promote the overuse of antibiotics: (1) lack of education (2) prior experience (3) patient's expectations and (4) economics.¹ Lack of education on both the part of the physician and patient currently contribute to the problem. Recent data have demonstrated that despite the knowledge that colds, upper respiratory tract infections, bronchiolitis and bronchitis are a set of infections that have a viral etiology in the majority of cases, between 44% and 75% of patients will leave a physician's office with an antibiotic prescription.^{2,3}

Patients also may lack an understanding of the differences between viral and bacterial infections. For those patients who have been previously and "successfully" treated with antibiotics for a viral illness, the demand is reinforced in the future for similar therapy for symptoms that clearly may be secondary to viral infection simply based on past experiences. This leads to expectations from the patient that an antibiotic should be prescribed for something as self-limited as a common cold.

Whether real or perceived, it has been documented that a patient's expectations for antibiotics affect a physician's prescribing behavior. In a recent article by Bauchner et al,

pediatricians were asked to complete a questionnaire in an attempt to understand how parents influence prescribing patterns.⁴ Forty percent of the those surveyed stated that 10 or more times in the past month a parent had requested an antibiotic even though the clinician felt it was unnecessary. In addition, 48% reported that parents always, most of the time or often pressured them to prescribe antibiotics when their children were ill but antibiotics were not indicated. In follow-up questions it was found that approximately one-third of physicians reported they occasionally or more frequently complied with this request. Fifty-four percent indicated that parental pressure in contrast to concerns about practice efficiency (19%) or legal liability (12%) contributed most to their inappropriate use of antibiotics.

In an attempt to educate the public, the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention and the American Society of Microbiology recently released a pamphlet to educate parents about antibiotics.* It emphasizes the differences between viruses and bacteria, describes how resistant bacteria emerge, reviews appropriate indications for antibiotics and counsels parents that all infections do not require antibiotics for resolution of symptoms. Patient education is essential if this cycle is to be broken. It is not unreasonable to think that if patients are educated about the appropriate indications for antibiotic therapy, they may soon question the physician on the role that a prescribed antibiotic has in their illness. This in turn may alleviate some of the pressure physicians currently feel to write that prescription.

Since most physicians are aware that overprescribing antibiotics is a major problem in our society today, it would seem that providing additional education or information alone would be insufficient. To facilitate these changes the development of supportive materials, mechanisms to implement changes and supportive structures in health care organizations will be required.

Key elements include evidence-based recommendations for diagnosis

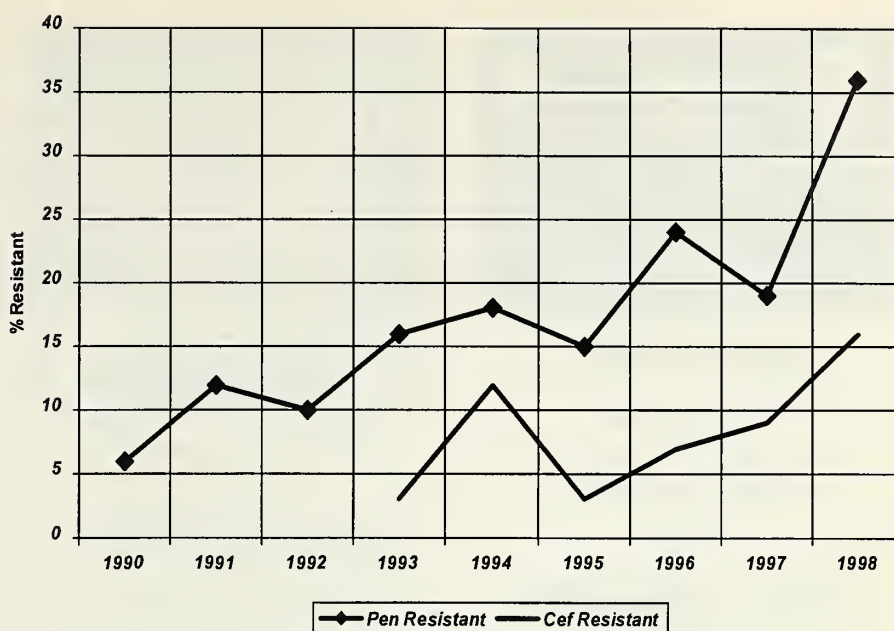


Fig. 1: Percent of invasive isolates of *Streptococcus pneumoniae* that have been resistant to penicillin (Pen) and cefotaxime (Cef) from 1990-1998 at Arkansas Children's Hospital.

and treatment with professional society support; materials for patient education; and the information to facilitate provider-patient communication. For example, guidelines are currently available for the management of otitis media with effusion and pharyngitis in young children, but many clinicians are hesitant to follow such guidelines because they were developed on a national level and lack recognition of the local needs.^{5,6} The development of such practice guidelines are usually much better supported if they are part of a multifaceted intervention.

Likewise, formal continuing medical education conferences and the distribution of printed material usually do not impact clinicians behavior unless they are reinforced by other strategies. Many studies have shown that education at an individual or small group level, along with peer education, are effective strategies to promote changes in prescribing behaviors. This, however, is difficult to do on a large scale because of the expense involved in training and supporting educators. Convincing the local leaders of the medical community to change their practices will result in the eventual change throughout the community, leading to a change in the standard of care. Identifying and educating these opinion leaders as a priority group can

be effective, especially if resources are limited. Educating the future health care providers about the importance of judicious antibiotic use before they start prescribing antibiotics is also mandatory.

Diagnostic uncertainty is an ever-present barrier to the appropriate treatment of many infections. Some uncertainty is inevitable, but this uncertainty should occur infrequently when the appropriate clinical evaluation and interpretation of these data are made. For example, pneumatic otoscopy is an inexpensive and useful technique that may aid the clinician in correctly diagnosing acute otitis media. Likewise, a positive throat culture for group A *Streptococcus* should reduce the diagnostic uncertainty of a case of pharyngitis. The inadequate knowledge of the signs/symptoms and natural history of viral illnesses also contributes to the overuse of antibiotics. For example, the differentiation of a bacterial sinusitis from a rhinitis of viral etiology is usually based upon the number of days of illness. Those with more than 10 days of illness are much more likely to have an illness where the use of an antibiotic should be considered. The use of such clinical evaluations will give the clinician the data they require so they are not prescribing an antibiotic "just in case" the illness is bacterial.

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Emerging Problems with Resistance

There is a strong association between the magnitude of antibiotic use and the emergence and spread of antibiotic resistant bacterial isolates. Pediatric populations are therefore important targets for efforts at reducing unnecessary antibiotic use. Environments that are unique to children, such as day care and school, enhance the transmission and spread of these isolates.

Acute otitis media is the most common indication for antibiotic prescribing in the United States with an estimated annual cost of \$3.5 billion. In 1980, 4,206,000 prescriptions were written for amoxicillin and 876,000 were written for cephalosporins for the treatment of acute otitis media. In 1992, this number had increased to 12,381,000 for amoxicillin (194% increase) and 6,892,000 for cephalosporins (687% increase).⁷ Based on these data, it is estimated that 30 million prescriptions will be written for the treatment of acute otitis media in 1999 alone.⁴

As if these data were not bad enough, it also has been noted that more prescriptions are being written for the expensive and broad-spectrum antibiotics for illnesses that could have been treated just as effectively with a less expensive and narrower spectrum drug.⁷ Since *S. pneumoniae* is the most common bacterial agent responsible for acute otitis media it would be reasonable to assume that an increase of antibiotic resistant pneumococci might be found if the increase in antibiotic use has played a role in the development of resistance. Clinicians need not venture out of Arkansas to find such data. At Arkansas Children's Hospital, the percentage of penicillin resistant isolates in invasive pneumococcal disease from 1990-1998 has reached 36%, with up to 16% being cephalosporin resistant (Fig. 1).

The dramatic emergence of multiple antibiotic resistant *S. pneumoniae* has led to many questions concerning the outpatient treatment of common illnesses such as otitis media. To help with these important issues, the Drug-resistant Streptococcus pneumoniae Therapeutic Working Group recently released its rec-

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ommendations for the treatment of acute otitis media in this era of increased pneumococcal resistance.⁸

The Therapeutic Working Group concluded that amoxicillin should remain the first line antibiotic for the treatment of acute otitis media. The initial dose of amoxicillin should be increased from 40-50 mg/kg/day to 80-90 mg/kg/day in patients at risk for an infection due to a resistant isolate of pneumococcus. Such factors would be age, recent antibiotic exposure and day-care attendance. Thus, a patient older than 2 years old with no antibiotic exposure within the last three months and no day-care attendance would be a candidate for amoxicillin in the standard dosage. For patients with clinically defined treatment failures after three days of therapy, the three agents considered the most effective include amoxicillin-clavulanate (80-90 mg/kg/day of amoxicillin and 6.4 mg/kg of clavulanate), cefuroxime axetil (30 mg/kg/day) or ceftriaxone (50 mg/kg/dose).

Duration of Antibiotic Therapy

One of the most common causes for treatment failures when antibiotic therapy is used is poor patient compliance. Poor compliance appears to be especially common with longer treatment courses because patients stop taking their medications once they feel better. It is therefore quite important that if antibiotic agents are going to be used, an acceptable antibiotic regimen should be initially chosen.

In a recent review of 27 prospective and randomized trials comparing shorter and longer treatment duration for acute otitis media, short course therapy (five days) was found to be as effective as the traditional treatment of 10 to 14 days.⁹ The exceptions were for children with chronic otitis media, other chronic medical conditions and those younger than 2 years old. When these data were subjected to a meta-analysis similar conclusions were reached.¹⁰

Although there are fewer studies to support a shortened course of therapy

for sinusitis, the organisms encountered are virtually identical to those causing acute otitis media. Information regarding shortened course therapy has been mostly limited to maxillary sinusitis in adults. In the best study done to date, 80 adult patients with acute sinusitis were treated with a three-day course of trimethoprim-sulfamethoxazole. This treatment regimen was found to be as effective as a 10-day course of therapy.¹¹ These results are encouraging but should be viewed as preliminary at this time.

For Group A β -hemolytic *Streptococcus tonsillopharyngitis*, a 10-day course of penicillin is based upon sound scientific data. There have now been more than 20 studies with antibiotics other than penicillin that support shorter duration therapy.⁹ It would therefore appear that six days of therapy with amoxicillin, four to five days of therapy with various oral cephalosporins (e.g., cefpodoxime proxetil, cefuroxime axetil) or five days of therapy with azithromycin (10



Clockwise (L-R): Bill Smith, Keith McCullough, Stan Russ, Stephen Chaffin and Jim Strawn.

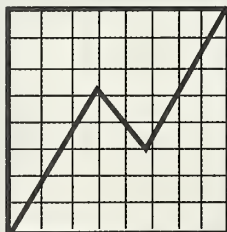
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mg/kg for all five days) may be considered as reasonable alternatives to the traditional 10-day course of penicillin.

Conclusion

With the increasing numbers of drug resistant organisms encountered in our practices today, the need for the judicious use of antibiotics is essential. Although any changes we make in our antibiotic prescribing practices will probably not have a large impact in the resistance of the organisms we encounter today, it could have a tremendous impact on the resistance of the organisms we will encounter in the years to come. It will take a conscious effort on each of us to change our prescribing habits and a commitment to educating our patients in order to reach these goals. ■

References

1. Belongia EA, Schwartz B. Strategies for promoting judicious use of antibiotics by doctors and patients. *Brit Med J* 1998;317:668-671.
2. Gonzales R, Steiner JF, Sande MA. Antibiotic prescribing for adults with

colds, upper respiratory tract infections, and bronchitis by ambulatory care physicians. *JAMA* 1997;278:901-904.

3. Nyquist AC, Gonzales R, Steiner JF, Sande MA. Antibiotic prescribing for children with colds, upper respiratory tract infections and bronchitis. *JAMA* 1998;279:875-877.
4. Bauchner H, Pelton SI, Klein JO. Parents, physicians, and antibiotic use. *Pediatrics* 1999;103: 395-398.
5. Otitis Media Guideline Panel. Clinical practice guideline: Otitis media with effusion in young children. Rockville, MD: Agency for Health Care Policy and Research, 1994 (report No. 94-0622).
6. Bisno AL, Gerber MA, Gwaltney JM, Kaplan AL, Schwartz RH. Diagnosis and management of group A streptococcal pharyngitis: A practice guideline. *Clin Infect Dis* 1997;25:574-583.
7. McCaig LF, Hughes JM. Trends in antimicrobial drug prescribing among office-based physicians in the United States. *JAMA* 1995;273:214-219.
8. Dowell SF, Butler JC, Giebink GS, et al. Acute otitis media: Management and surveillance in an era of pneumo-

coccal resistance—a report from the Drug-resistant *Streptococcus pneumoniae* Therapeutic Working Group. *Pediatr Infect Dis J* 1999;18:1-9.

9. Pichichero ME, Cohen R. Shortened course of antibiotic therapy for acute otitis media, sinusitis, and tonsillopharyngitis. *Pediatr Infect Dis J* 1997;16:680-695.
10. Kozyskyj AL, Hildes-Ripstein GE, Lonstaffe SEA, Wincott JL, Sitar DS, Klassen TP, Moffatt MEK. Treatment of acute otitis media with a shortened course of antibiotics: A meta-analysis. *JAMA* 1998; 279:1736-174.
11. Williams JW, Holleman DR, Samsa GP, Simel DL. Three days therapy for acute sinusitis. *JAMA* 1995;273: 1015-1021.

* "Your Children and Antibiotics," item # HE0219; AAP, PO BOX 747, Elk Grove Village, IL 60009-0747; phone (800) 433-9016; fax (847) 228-1281; \$34.95/100 copies.

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CARDIOLOGY



The Waves of the Electrocardiogram: Part 2 The QRS Complex

ALLISON SHAW, MD — JOE K. BISSETT, MD — J. DAVID TALLEY, MD

This is the second article in our series of discussions about the electrocardiogram. In this review, we will focus on the formation of the QRS complex and the clinical significance of Q waves.

Patient Presentation

A 70-year-old female presented with hematochezia. She had no prior cardiac history, and the initial electrocardiogram was normal (Fig. 1). During her hospital stay, she developed substernal chest discomfort with non-specific T wave changes. She was normotensive and had a regular rhythm without any murmurs or gallops. The lungs were clear to auscultation. The patient was transferred to the coronary care unit where she was treated medically. The peak creatine kinase was 2600 IU/L and the troponin I was 43 ng/mL. At cardiac catheterization, she had a high-grade occlusion of the left anterior descending coronary artery that was treated via percutaneous coronary intervention. Subsequent electrocardiograms showed the development of new Q waves in the anterior leads (Fig. 2).

Discussion

Traditionally, the QRS complex has been considered to be due to ven-

Table 1.
Complete Problem List

1. Coronary Artery Disease	
Etiology:	Atherosclerosis
Anatomy:	Cardiac catheterization → Left anterior descending 99%, circumflex 20%, right coronary 20% Coronary angioplasty → left anterior descending, successful
Physiology:	A. Presentation with acute myocardial infarction B. Cardiac catheteriza- tion → left ventricu- lar ejection fraction, 50% C. ECG → anterior Q- wave myocardial infarction
Functional Capacity:	II
Objective Assessment:	C
2. Arthritis	
3. Hematochezia → rectal cancer	

tricular depolarization that is mediated through voltage-gated sodium channels. Abnormalities of the QRS often

provide clues to the etiology of cardiovascular diseases.

Ventricular depolarization. Any initial negative deflection is termed the Q wave. If it is followed by an upward deflection, this is known as the R wave. A secondary upward deflection is referred to as an R' (prime) wave. The following negative deflection is characteristically referred to as the S wave. In normal depolarization, the sequence of activation of the ventricular myocardium begins on the left side of the interventricular septum and travels in a rightward and anterior direction. This is recorded as an initial small Q wave in the left-sided leads. The major vector during the mid-point of depolarization is directed leftward and inferiorly, hence the usual large inscription of R waves in the left-sided leads (this large vector force is due to left ventricular mass).

QRS duration. An important part of interpretation of the electrocardiogram involves the measurement of the QRS duration. A normal QRS duration is less than 120 milliseconds. Prolongation of this interval suggests a defect in interventricular conduction that is usually related to block or

slowed conduction within the specialized tissue (His-Purkinje cells) of the bundle branches. There are specific criteria for the diagnosis of bundle branch blocks. The diagnosis of right bundle branch block can be made when QRS in question meets the following criteria: 1) prolongation of the QRS to 0.12 second or more; 2) an rsr', rsR' or rSR' pattern in lead V1 or V2; and 3) a wide S wave in leads V6 and I.¹ Similarly, there are specific criteria for the diagnosis of left bundle branch block. These criteria are as follows: 1) The QRS is 0.12 second or more in duration; 2) Leads V5, V6, I and aVL have broad and notched or slurred R waves; 3) Q waves are absent in the left-sided leads (possibly except aVL); 4) The R peak time is prolonged to more than 0.06 second in lead V5 or V6; and 5) in V1 and V3 there are small initial r waves in the majority of cases, followed by wide and deep S waves.

QRS axis. During evaluation of the ECG, the axis also should be determined. The normal QRS axis is usually considered to be between -30 and +110 degrees in the frontal plane. Abnormal right axis deviation may be seen in young adults, chronic obstructive pulmonary disease (even without cor pulmonale), lateral myocardial infarction and left posterior hemiblock.² Abnormal left axis deviation is usually caused by a left anterior hemiblock or an inferior myocardial infarction.

Q waves. Another important step in electrocardiographic interpretation is the search for abnormal Q waves. Q waves are normal in some leads (small Qs in I, aVL, V5, V6). This is thought to be due to the normal left to right septal depolarization. However, Q waves also may represent loss of electrical forces. In one retrospective study, the mortality of patients with non-Q wave infarcts was only 9% while that of Q wave infarcts approached 20%.³ The course of non-Q wave infarcts in the same study was shown to be more malignant, with a higher rate of reinfarction. Recent trials have compared the results of interventional ver-

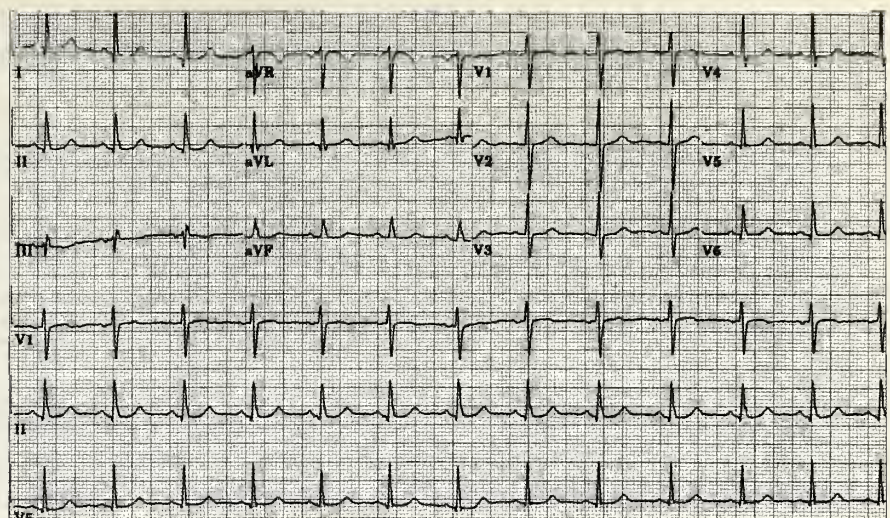


Fig. 1. The electrocardiogram shows a normal QRS complex in our patient before the development of symptoms.

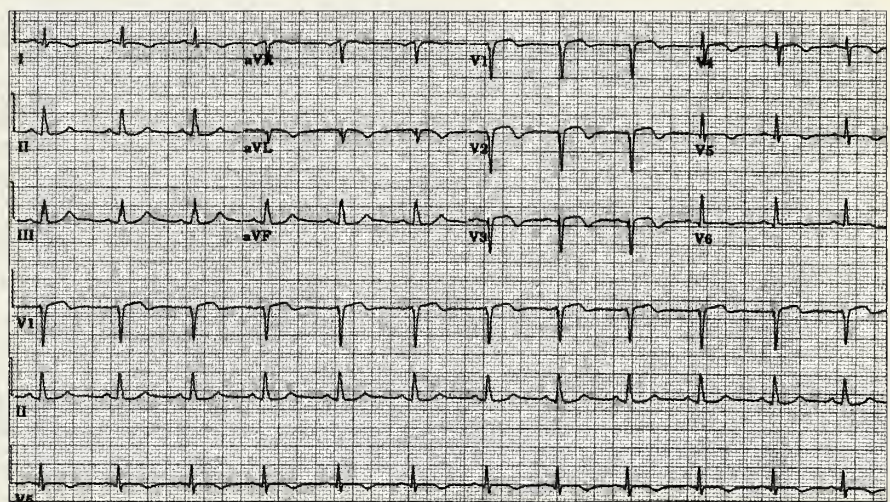


Fig. 2. The electrocardiogram shows the interval development of Q waves in the anterior leads with chest pain.

sus conservative therapy in the management of non Q wave myocardial infarction.

Q wave regression. The absence of abnormal Q waves on the electrocardiogram does not rule out the possibility of a patient having had a prior transmural infarction. Even after patients have had a known Q wave infarction, Q waves may actually regress after a period of time. There are several hypothesis for this regression of Q waves in these patients. Though Q waves can represent myocardial injury, they do not necessarily indicate irreversible cell damage.⁴ Therefore, recovery of "stunned" cells in this area of myocardium may recover function and Q waves regress. If irreversible damage has occurred in the myocardium, scarring of the affected area may

lessen the magnitude of the involved segment. Occasionally, reinfarction may occur in an area that involves the opposite wall of the area that is represented by the Q wave. The two areas effectively are "canceled" by each other electrically and result in changing the direction of the depolarization vectors. This has previously been termed the contrecoup effect. The development of a ventricular conduction disturbance can actually mask previously noted Q waves. With ventricular conduction disturbances there is a change in the direction of the vector of depolarization of the ventricular myocardium. It also has been suggested that in order to compensate for the area of ineffective myocardium the surrounding myofibrils will often hypertrophy. This may result in the return of elec-

trical forces to this area of the myocardium and result in normalization of the depolarization vector.

Non-ischemic Q waves. Q waves may be secondary to the orientation of the heart (vertical or horizontal) in the thorax. These Q waves mimic infarction in leads that are perpendicular to the position of the heart and represent so-called pseudoinfarction. Q waves also may be generated in patients with ventricular conduction abnormalities or with ventricular hypertrophy. Many metabolic derangements result in the formation of Q waves. For example, in hyperkalemia there may be the development of Q waves. This is thought to be secondary to the loss of electrical forces from the myocardium that is associated with a decreased resting membrane potential and subsequent lowered amplitude of the action potential (increased extracellular potassium changes the normal ratio).⁵ Pancreatitis has been as-

sociated with the transient development of Q waves, but the clinical significance of this is not fully understood. It has been suggested that perhaps pancreatic enzymes cause actual myocardial damage though currently this is only an association. Q waves have been associated with traumatic injury. Patients who suffer blunt trauma and myocardial contusions or penetrating trauma may both develop Q waves as a result of injury.

The study of the duration, axis and morphology of the QRS complex can be a valuable clinical tool. ■

References

1. Willems JL, Robles de Medina DE, Bernard R, et al. Criteria for intraventricular conduction disturbances and pre-excitation. *J Am Coll Cardiol* 1985; 5:1,261-1,275.
2. Chou T-C. Right ventricular hypertrophy. In: Chou TC, Knilans TK, eds. *Electrocardiography in Clinical Practice*, 4th ed, Philadelphia, Penn-

sylvania: WB Saunders, 1996:54-69.

3. Hutter AM, DeSanctis RW, Flynn T, Yeatman LA. Nontransmural myocardial infarction: A comparison of hospital and late clinical course of patients with that of matched patients with transmural anterior and transmural inferior myocardial infarction. *Am J Cardiol* 1981; 48:595-602.
4. Goldberger AL. Q waves of myocardial infarction. In: Trumbold C, ed. *Myocardial Infarction: Electrocardiographic differential diagnosis*. St. Louis, Mo: Mosby, 1984:15-28.
5. Goldberger AL. Noninfarctional myocardial injury: acute myocardial injury patterns. In: Trumbold C, ed. *Myocardial Infarction: Electrocardiographic differential diagnosis*. St. Louis, Mo: Mosby, 1984:107-117.

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Doctors Not Required to Provide Deaf with Interpreters in All Cases

BY DAVID IVERS, J.D.

Does a doctor's office have to provide a sign language interpreter if a deaf person requests it? Almost 10 years after the Americans with Disabilities Act was passed, this question comes up again and again.

Most physicians are well aware that, like hotels, movie theaters, laundromats, law offices, hospitals and other places of public accommodation, medical offices are required to comply with the Americans with Disabilities Act of 1990 (ADA). Under Title III of the ADA, no individual may be discriminated against on the basis of disability in the "full and equal enjoyment" of goods and services offered by places of public accommodation. This means that a medical clinic or other public accommodation generally must provide "auxiliary aids and services" if needed by the disabled person.

So does this mean that a doctor must provide a sign language interpreter? Not necessarily. The guiding principal to always keep in mind is that you must provide "effective communication." This may mean anything from use of pen and note pad to typing on a computer terminal to hiring an interpreter.



In some situations, an interpreter will probably always be required. The justice department's interpreting regulations note: "It is not difficult to imagine a wide range of communications involving areas such as health, legal matters and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication." As an example, the regulations state that a pen and note pad would be insufficient to permit effective communication when the matter to be decided is whether major surgery is necessary. On the other hand, common sense says that if a patient presents herself with an ordinary sinus infection, you would not need an interpreter in order to treat her if she is able to read and write or use a computer terminal. In between those two extremes are many different scenarios that can only be decided on a case-by-case basis.

What if the doctor and patient disagree on whether an interpreter is necessary? The decision is left to the doctor's office, not the patient. Wield this power carefully since you may be liable for a violation of the ADA if your chosen method proves ineffective. The primary remedy under the ADA is injunctive relief (i.e., ordering you to comply), but a civil penalty also may be assessed, particu-

larly if you are found to have acted in "bad faith." A doctor's office should be aware that in deciding what type of auxiliary aid is needed, the law "strongly encourages" public accommodations to consult the person with the disability.

These cases can carry a lot of public sympathy. Consider, for example, the situation in New York where a hospital allegedly failed to supply an interpreter for a man who attended a Lamaze birthing class with his wife at the hospital. Later on, the hospital also failed to provide an interpreter when the child was placed in the neonatal intensive care unit, telling him he could use a TTY, a device that allows deaf persons to communicate over the telephone. Now the hospital has an image problem as well as a major lawsuit.

In short, if you can communicate effectively without an interpreter, the law does not require you to hire one. But if a note pad, computer, TTY or other aide won't do the job effectively, the law requires that you provide that service. To obtain a referral to a qualified interpreter, you may call your local state Vocational Rehabilitation Office or the Disability Rights Center (800-482-1174). Sometimes a deaf patient will bring to the office a friend or family member who can sign, but they still may need you to provide a qualified, professional interpreter to ensure accurate communication and protection of their privacy.

In cases where you do decide to hire an interpreter, the going rate in Arkansas is about \$50 an hour, usually with a two-hour minimum. Many doctors want to know if they can charge the patient for that expense. The answer is no. Businesses must bear the cost of providing accommodations to the disabled, whether it is a wheelchair ramp or an interpreter. In passing the ADA, Congress reasoned that society as a whole benefits in the long run from the integration of the disabled into the mainstream of society. ■

Sources

1. Americans with Disabilities Act of 1990, as amended, 42 U.S.C. §12101 et seq.
2. ADA regulations at 28 C.F.R. §36.303 and App. B.

Ivers is an attorney with Mitchell, Blackstock, Barnes, Waggoner & Ivers, general counsel to the Arkansas Medical Society.

PEOPLE+EVENTS

HONORED

Dr. Stallings Earns Doctor of the Year Award

Dr. Joe Stallings of Jonesboro is the Arkansas Family Doctor of the Year, chosen by the Arkansas Academy of Family Physicians.

Dr. Stallings has maintained his family practice — including obstetrics, pediatrics, nursing home care and hospital patient care — for more than 25 years. He and his wife, Mary Ann, have two daughters, Jenny and Mary Margaret.

AMA Hands Out Physician's Recognition Awards

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for August include **Dr. Ernest W. Archers**, Van Buren; **Dr. Katherine Henry Baltz**, Little Rock; **Dr. Robert W. Barnes**, Little Rock; **Dr. Joe H. Dorzab**, Fort Smith; **Dr. William C. Furlow**, Conway; **Dr. John O. Lytle**, Pine Bluff, and **Dr. Robert J. McGowan**, Little Rock.

Dr. Toon Retires After 33 Years of Practice

Dr. Don Toon, who had a private practice in the Ashley County area for 33 years, was the guest of honor recently at a reception at Ashley County Medical Center.

Dr. Toon, who earned his medical degree from the University of Arkansas School of Medicine in 1965, played a major role in establishing the Ashley County Medical Center. He was one of the seven original members of the hospital's board.

He and his wife, Nancy Stephens Toon, are the parents of three children.

Rogers Urologist Appointed to Prostate Committee

Dr. Jan Turley of Rogers recently was named to the Oversight Committee on Prostate Cancer, which seeks to raise awareness about the disease in Arkansas.

"I'm amazed how many [men] haven't had their prostate checked and/or had a PSA blood test," Dr. Turley told the Benton County Daily Record. "They're just not aware of it."

The committee will seek ways to educate men about early detection of the disease and evaluate screening programs.

Van Buren County Doctor Ends 47-Year Career

Dr. John Hall, who practiced in the Clinton area for 47 years, recently was honored with a reception at the First Service Bank community room.

Visitors were treated to a collection of photographs taken throughout Dr. Hall's career.



Legislators at the Boone County Medical Society fish fry included (bottom row, left to right) Sen. Gary Hunter, former Rep. Bob Watts, former Sen. Steve Lueff, Rep. Randy Lafferty, (top row, left to right), Rep. Mike Hathorn, Rep. Jimmy Milligan, Rep. Jim Milum and Sen. Jon Fitch. Dr. Tom Langston, president of the Boone County Medical Society (bottom row, far right), presented plaques to Watts and Lueff.

Boone County Medical Society Celebrates Legislation Efforts

More than 200 physicians, business owners, community leaders and legislators gathered for the Boone County Medical Society's Legislative Appreciation Fish Fry at the home of Dr. Sam Scroggins.

Current and former legislators were commended for their efforts to improve health care in the area. Physicians celebrated lobbying efforts that brought about \$780,000 in state funds to the Claude Parrish Radiation Therapy Institute on North Arkansas Regional Medical Center.

OBITUARY

Dr. Jerry Donald Morgan, 64, of Stuttgart died Aug. 22, 1999, at Baptist Medical Center in Little Rock.

He began a family practice in 1965 at Stuttgart Medical Clinic. He was a former chief of staff at Stuttgart Regional Medical Center and a member of the American Academy of Family Practitioners, American Medical Association and the Arkansas Medical Society.

Dr. Morgan was honored in 1998 by the University of Arkansas for Medical Sciences as a Distinguished Teacher of Medical Students.

He is survived by his wife, Martha Osburn Morgan, three sons and one daughter.

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Special Report: Bouncing Back

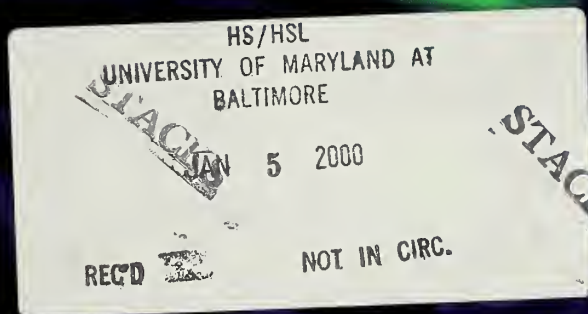
Committee Helps Doctors
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Doing His Part

Lane's Work
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Life

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COMMENTARY



In Praise of Pioneers and Medical Miracles

JERRY BYRUM, MD

As our century and millennium come to a close, it is a natural time for those of us in medicine to reflect on where we have come from and where we are going.

As I think about these things, I am immediately struck with a profound sense of gratitude for the work that has been accomplished in our field over the past 100 years. We are the benefactors of the contributions of countless talented, imaginative, pioneers in medicine who have contributed to our vast armamentarium in the fight against disease. Imagine how a physician from 1900 would view medicine today. The progress in medicine — and in our country in general — is staggering. It is helpful to reflect on some of the accomplishments.

In 1900, for the most part, the scope of medical care in our country was very limited. Poor modes of transportation, coupled with limited numbers of physicians, limited medical facilities and limited medical and surgical treatment modalities, made for very primitive medical care by today's standards. A visit to almost any Arkansas cemetery yields numerous examples of this. It is easy to find paired tombstones with a mother's marker beside her infant's marker. An inspection of an infant's tombstone generally yields a date of birth and date of death that is the same day. Beside it, the mother's tombstone has the same date of death as the infant. It is rare to see this pairing of tombstones after 1940. Today, we take safe deliveries almost for granted, I am thankful.

In 1900, a host of infectious diseases were present in Arkansas and the United States in general, with which physicians of 2000 have very little experience. Dreaded diseases such as smallpox, typhoid fever, diphtheria, tetanus, polio, the severe form of scarlet fever and many other infectious diseases have almost vanished from our population.

Improved sanitation, less crowded living conditions, national vaccine programs, an understanding of the basis of infectious disease, the development of life saving medicines, better working conditions, less pollution, improved water supplies, quality nutrition and improved food supplies have all contributed to this success. I have come to understand this situation much more clearly after having visited Russia seven times and encountering vaccine preventable diseases such as diphtheria. We shouldn't take for granted what has been accomplished here. We have made great progress in this country in this regard, and I am thankful.

Many diseases today are cured with the direct benefits of life-saving medicines. In 1900, many of these same diseases were fatal. It took imagination, hard work, financial risk and courage to bring these into production.

Who can forget the dramatic appearance of penicillin in the late 1930s and early 1940s. Think of the daring it took to actually inject this material into a living human being for the first time. It worked (Well, that is, eventually it worked. The first man to receive penicillin died after initially improving on the medication, only to relapse after the researchers ran out of it). The practice of medicine was changed forever.

Today there is a multibillion dollar industry devoted to research, de-

velopment and production of life-saving and life-enhancing medications. Brilliant minds spend their lives in pursuit of finding medical cures for disease, and I am thankful.

Then, there is the drama of surgery. The examples of progress are too numerous to cite. Think of the first heart surgeries. Before penicillin, rheumatic fever caused many cases of mitral valvar stenosis. Some of the first heart surgeries involved finger dilatation of the stenotic mitral valve through a incision made in the wall of the beating heart. From this start, we have the incredible cardiac surgeries of today with coronary artery surgery and angioplasty, heart valve replacement and repair, heart transplantation and arrhythmia treatment to name a few. In other fields, such as obstetrics, gynecology, general surgery, orthopedics, otolaryngology, neurosurgery,

Before penicillin, rheumatic fever caused many cases of mitral valvar stenosis. Some of the first heart surgeries involved finger dilatation of the stenotic mitral valve through a incision made in the wall of the beating heart.

ophthalmology, urology and others, the progress is unprecedented. I am in awe of what you do, and I am thankful.

There have been incredible advancements in other fields of diagnosis, surgical support and medical supplies. Things like anesthesia methods, surgical materials, surgical techniques and post op care have all vastly improved. Lasers, cautery, endoscopic devices, angiograms, robotic equipment, monitoring equipment, electronics, CT, MRI, MRA, PET and other alphabet soup abbreviations have

contributed greatly to our ability to help people. The list goes on and on and on, and I am thankful.

Then, there are those incredible people who render medical care. They are you — physicians, pharmacists, nurses, physicians assistants, therapists, technicians, administrators, office staff and others, all those who take care of people. You are the best ever at what you do, and I am thankful for you.

I am thankful to live here in Arkansas, right at this moment. It is a beautiful land with the greatest people in the world. It is a land of plenty. We truly are living in the best of times. Lastly, I am thankful to our Creator who gives us life and breath. I am indeed very thankful. ■

Dr. Byrum is a Little Rock pediatrician and a member of the editorial board of The Journal of the Arkansas Medical Society.

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LETTERS

Dear Ms. Hicks:

The special report, "Collective Bargaining is AMA's Answer to Managed Care Woes," by Natalie Gardner in the August 1999 issue of *The Journal* was of interest to us, especially the quotes by Dr. Sandra Johnson, a dermatology resident at the University of Arkansas for Medical Sciences. We understand that Dr. Johnson's observations were about residents in general, especially those that she has contacted through the AMA meetings, and were not specifically about residents at UAMS.

We wish to clarify the work environment for residents at the University of Arkansas. Each year, UAMS educates approximately 500 resident physicians within 50 training programs. Certainly, some of the training programs are more stressful than others and require longer working hours. The Graduate Medical Education (GME) Committee at the University of Arkansas College of Medicine considers the issue of work environment, work hours and support of resident education very seriously. The committee is composed of training program directors, the assistant dean for graduate medical education, representatives from each of the three major participating teaching hospitals, eight chief residents and eight residents elected by their peers with full voting status.

In order to ensure that residents have an appropriate work environment, the GME Committee developed a work hours and work environment policy in 1998. This policy specifies that each resident shall work no more than an average maximum of 80 hours of assigned clinical duties per week; that emergency room and night float shifts be limited to approximately 12 consecutive hours of patient care and each shift shall be separated by 12 hours free from clinical duties.

(Letters continued on Page 241)



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Letters

(Continued From Page 239)

cal responsibilities; that each resident shall have a monthly average of one day in seven free from clinical duties and expectations; and that each resident shall be on in-house call no more than an average of every third night.

In addition, residents have staff physician supervision appropriate to the skill level, call rooms for all residents who take in-house call, and adequate ancillary support for patient care.

In order to assure compliance with the policies of the GME Committee, residents complete yearly confidential surveys about these issues. In addition, each training program undergoes an internal review by a faculty and resident panel approximately every two to three years. Through confidential resident interviews, the GME Committee is able to monitor and make positive changes as indicated.

This year, the GME Committee formed a Residents Council, composed of 16 resident members who represent the housestaff body. Their projects include developing a better communication system for all residents to exchange information about their educational and work environments and to develop a process by which residents may raise concerns in a confidential and protected manner. We believe that the above measures will ensure a positive environment for education of residents at UAMS. ■

Sincerely,

I. Dodd Wilson, MD
Dean, College of Medicine

Jeanne K. Heard, MD, Ph.D
Assistant Dean for Graduate
Medical Education

Chris E. Smith, MD
Chair, Graduate Medical
Education Committee

WHAT WE'VE DONE FOR YOU LATELY



Top 50 Things AMS Does for Its Members

By DAVID WROTEN

In discussing the purposes of this monthly column, Dr. Mike Moody of Salem suggested that perhaps it should be titled "What Have You Done for Me Lately?" since that seems to be the question of the day.

It is a legitimate question for which there are some very good answers. Unfortunately, either we are not doing a very good job of communicating those answers or physicians simply are not receiving the message.

There are almost 100 physicians involved in the Arkansas Medical Society's long-range planning effort. As you might imagine, there are dozens of suggestions for things that the AMS should be doing. The good news is that the AMS is doing many of them. The bad news, as pointed out by the well-intentioned suggestions, is that too many AMS members are unaware of the many things the AMS does for them and their patients.

Finding better ways to communicate with physicians will be a major goal of the AMS. But, for now, here are 50 things that the AMS does for you. Share them with a colleague.

The Top 50

(In no particular order)

1. Publishes *The Journal of the Arkansas Medical Society* monthly.
2. Publishes *AMS News Briefs*, a monthly newsletter.
3. Publishes *The Legislative Update*, a newsletter during legislative sessions.
4. Publishes an annual membership directory.
5. Sponsors seminars on coding, practice management and other issues.
6. Lobbies the legislative bodies, both federal and state.
7. Sponsors a doctor-of-the-day program to provide medical services to legislators and Capitol staff during the Arkansas General Assembly sessions.
8. Develops and promotes legislation beneficial to members, their patients and public health.
9. Maintains regulatory liaison with DHS (Medicaid), Arkansas Workers' Compensation Commission, Arkansas Insurance Department, Arkansas Department of Health, Arkansas State Medical Board, etc.
10. Participates on various task forces, boards, commissions and committees relative to health care issues.
11. Participates in the promulgation of rules related to health care, including prompt payment, workers' compensation fee schedules, Medicaid reimbursement and more.
12. Maintains liaison with other health-related organizations.
13. Sponsors/cosponsors fund-raisers for political candidates.
14. Participates in events and fund-raisers for charity organizations.
15. Executive staff and leadership serve as frequent speakers as experts in health care.
16. Sponsors a VISA Gold credit card program for members.
17. Sponsors health and other insurance programs for members and their clinics.
18. Sponsors a tax-deductible gift annuity program.
19. Sponsors an automobile leasing program for members.
20. Created a statewide managed care organization (AMCO) to assist physicians with negotiating and contract review. AMS no longer owns the entity, but it is alive and well.
21. Publishes legal information via the AMS' "Physician's Legal Guide."
22. Sponsors quarterly luncheons for

(Continued on Page 247)

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- Schedule nurse interview
- Order medical software
- Confirm on-call schedule

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Letter Urges Access to Sterile Syringes

Five groups are urging state medicine, pharmacy and public health officials to coordinate their efforts to provide access to sterile syringes to stop blood-borne diseases.

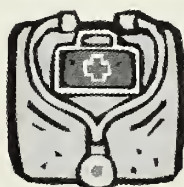
About a third of AIDS cases and half of hepatitis C cases in the United States are linked to injection drug use. Injection drug users, their partners and their children are in danger partially because of limited access to sterile syringes.

"The [American Medical Association] strongly urges state medical associations to join this important effort," said Dr. Thomas Reardon, AMA president, in a recent letter to state health officials. "Any action that will help reduce diseases like AIDS and hepatitis C — infections that pose a huge threat to public health — is clearly an action that physicians should squarely support."

Julie Scofield, executive director of the National Alliance of State and Territorial AIDS Directors, said, "The positive impact of increasing access to sterile syringes on disease prevention has already been demonstrated on both the state and local levels, as well as in numerous foreign countries. It's time for society to move be-

yond hypothetical concerns to tackle the immediate public health need to make sterile syringes available."

The groups backing the letter are the AMA, NASTAD, the American Pharmaceutical Association, the Association of State and Territorial Health Officials and the National Association of Boards of Pharmacy.



Groups Join to Campaign for Health Coverage

The American College of Physicians — American Society of Internal Medicine and the Catholic Health Association of the United States have created "Be Heard for Accessible and Affordable Healthcare," a grassroots campaign to push legislation for affordable health care.

"It's a national tragedy that more than 44 million Americans live each day without health insurance," said the Rev. Michael D. Place, CHA president and chief executive officer. "The number of uninsured Americans has increased by more than 15 percent in the past five years, at a time when the economy has enjoyed the longest sustained period of economic expansion in history."

The two groups plan to gather the names of thousands of Americans on petitions. So

far, requests for more than 90,000 petition forms have been made. The groups will talk to the White House, leaders in Congress and presidential candidates.

An electronic petition can be completed at the CHA web site, www.chausa.org/beheard or at the ACP-ASCM's web site at www.acponline.org/uninsured.

New MRI System Offers Quick View

Engineers at Johns Hopkins University in Baltimore have developed a system that will give doctors almost immediate information about heart damage.

The harmonic phase magnetic resonance imaging system, known as HARP MRI, will provide a clear view of heart muscles while a patient is inside a magnetic resonance imaging scanner.

Engineers Jerry L. Prince and Nael Osman developed the system to eliminate delays in processing and interpreting pictures from MRIs. Prince and Osman have applied for a patent for the system.

The engineers say the most promising use of the HARP MRI will be in cardiac stress testing, typically done with ultrasound equipment. "An MRI provides better resolution," Prince said. "You can see details better. With MRI tagging, you can see what's going on within the walls of a heart muscle. It can image the way the muscle is working.

There's no other technology that can do that now."

HARP MRI research is supported by a grant from the National Heart, Lung and Blood Institute of the National Institutes of Health.



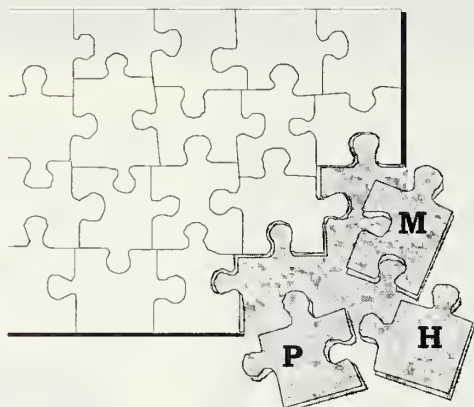
ACSM Conference Part of Special Supplement

The American College of Sports Medicine's conference, "Physical Activity in the Prevention and Treatment of Obesity and Its Comorbidities," is part of a November supplement to *Medicine & Science in Sports & Exercise*.

Complete manuscripts from the conference, along with an executive summary, are included. Findings from the conference show that physical activity is essential because it reduces the risk of comorbidities of obesity.

Dr. Claude Bouchard, co-chairman of the conference, said, "It is well established that regular physical activity has favorable effects on several of the comorbidities of obesity, particularly those pertaining to cardiovascular disease and type 2 diabetes. Some data also indicate that mortality rates are lower in the overweight and moderately obese men and women who are physically fit compared to the unfit." ■

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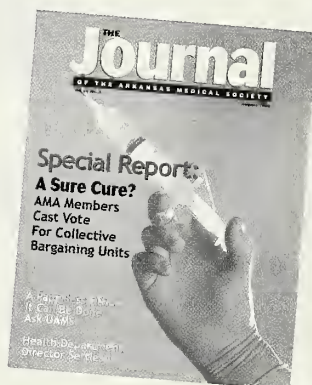
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DAYS GONE BY

Causes of Neuralgia

The term neuralgia is used to denote an affection, the chief characteristic of which is pain along the course of a sensitive nerve. The derivation of the word is from two Greek words, meaning nerve and pain.

The causes of neuralgia may be divided into four classes: first, systemic; second, local; third, idiopathic; fourth, diathetic.

Local causes maybe of a great many varieties. The nerve may be pressed upon by cicatricial tissue or a tumor of some kind. Nodes of the bone, syphilitic gumma, malignant or benign growths may impinge on the nerve.

The third class of cases may be denominated idiopathic. In these cases of neuralgia, there is discernible no cause of the disease. All that can be said of its pathological character is that there is a high degree of morbid sensibility.

The fourth class of cases has been here denominated diathetic. There are many cases in which sitting in a draft five minutes will cause an attack of neuralgia of as many days duration. There are others who will contract a severe neuralgia by standing on a wet pavement or floor a very short while.

The interference or disorder in the sensation of the nerve seems to be due to a constricting influence of the bone, or periostium, at the exit foramen of the skull. The effect of the diathesis is explained and the constricting influence is shown by the swelling of the bone on the occurrence of the contributing cause.

There seems to be a sub-acute periostitis around the nerve foramen, which is excited into an acute stage on the occurrence of the cause. Just as in sub-acute rheumatism of the joints, which is intensified in wet weather or exposure. On the swelling of the periosteum, or duramater, lining the exit canal through the skull, there is necessarily a constriction. ■

Dr. R.D. Thompson read portions of the above article to the society.

Reprinted from the "Proceedings of the 24th AMS Annual Session," May 1899.

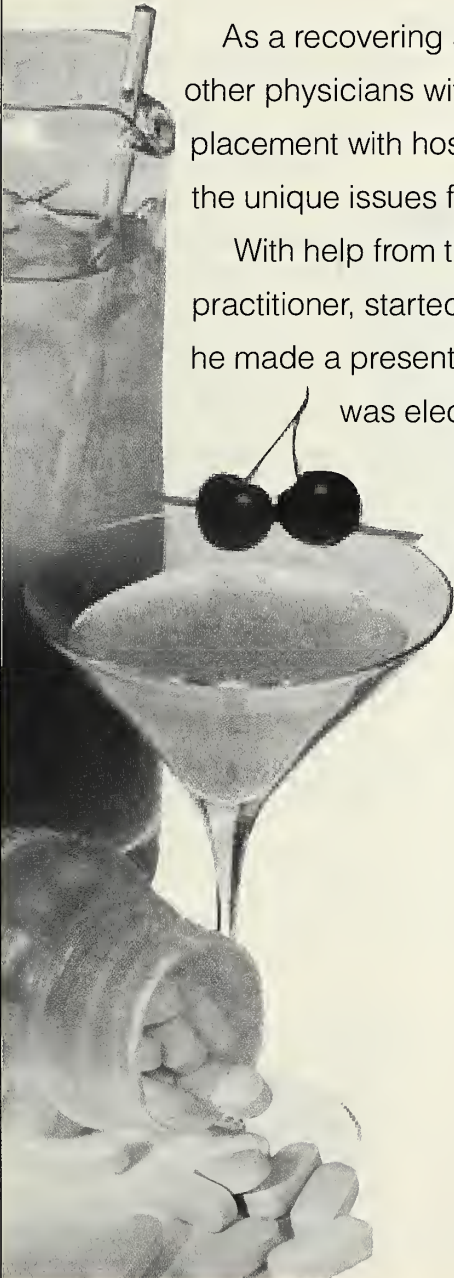
The Doc Stops Here

BY NATALIE GARDNER

Arkansas Medical Foundation Helps Doctors End Drug Abuse

As a recovering alcoholic, Dr. Joe Martindale of Benton was eager to help other physicians with the struggles he experienced. From renegotiating staff placement with hospitals to reopening a practice, Dr. Martindale understood the unique issues facing physicians with substance abuse problems.

With help from the Arkansas Medical Society, Dr. Martindale, a general practitioner, started a program for impaired physicians. In the early 1980s, he made a presentation to the Arkansas State Medical Board. Dr. Martindale was elected chairman of AMS' new committee, but the project was put on hold.



“After a period of time, we decided we really needed this committee,” Dr. Martindale said. “In 1987, I started selecting committee members and tried to appoint doctors who were in a state of recovery. That first year, we had no funding. I was heading it up out of my bedroom, and my wife was our secretary. That year, 12 physicians entered the program.”

Now the impaired physicians committee is its own entity — the Arkansas Medical Foundation — and Dr. Martindale is its medical director. Funding comes from not only AMS, but also State Volunteer Mutual in Tennessee and the Arkansas State Medical Board. The bulk of the foundation's funding comes from licensing fees. In the early 1990s, the state Legislature passed a law increasing licensing fees by \$20. That \$20 goes to support the impaired physicians program.

“Physicians are very much at risk with the availability of drugs to us,” Dr. Martindale said. “Now with managed care the way it is, doctors are stretched more. They are working their

practices during the day and the emergency room at night, sometimes in different parts of the state. They are maxed out and are reaching out for something to help them. That's when you get addicted."

The program is actively treating 58 physicians in the state, including one cardiologist, two neurosurgeons and one medical student. The foundation also offers help to dentists, dental hygienists, respiratory care practitioners and optometrists. Sixty-three percent of the dentists and dental hygienists in the program are facing state dental board action. Fifty-eight percent of the physicians in the program are facing action by the state medical board.

The foundation identifies physicians in need of services through recommendations and through the state medical board. Some physicians have been approached by the board and are in danger of losing their licenses; others are taking steps to get treatment before action is taken by the board, Dr. Martindale said.

"When we get a report on a physician, we have to make sure the information is valid," he said. "I call the physician and tell them exactly what I've heard, and then I make some recommendations."

Those recommendations could be anything from getting into a 12-step program, such as Alcoholics Anonymous, or being placed in an inpatient treatment program. Every physician who enters the program goes to a four-day inpatient evaluation

program targeted toward professionals. Arkansas Medical Foundation uses programs in Arkansas, Tennessee, Mississippi and Georgia.

Based on an evaluation, the foundation develops a treatment plan for the physician, who signs a contract with the foundation that locks them into a certain number of 12-step programs, outpatient treatments or physician support groups.

"We have two different contracts with the physicians," Dr. Martindale said. "One is a treatment contract that says they won't practice medicine until they are cleared. The other is an after-care contract that says the physician will continue to be supervised by us so we can determine if they are no longer under impairment."

Building a Relationship

The foundation's relationship with the state medical board has been the key to strengthening the impaired

physicians program, Dr. Martindale said.

"Until we had a relationship with the board, we had no teeth in this program. Now, if doctors become uncompliant with the treatment process, we have to report them to the board and that usually results in a physician's license being revoked."

Dr. Martindale is quick to dispel rumors that the foundation acts along with the state medical board.

"It is not our purpose to catch these people," he said. "We want to be able to know if someone is at risk to relapse. We're not there to be a policeman."

"I don't hammer on these doctors, but I do offer them a deal they can't refuse. I explain to them what they need to do, and if they don't, then I have to turn them over to the medical board and they do their own investigation. If that happens, odds are we'll have the same conversation again."

Program Successes

The foundation has its success stories. During the last three and a half years the program has had an office in Bryant, there have been six relapses out of about 150 doctors. There hasn't been a positive drug screening among participants since Jan. 4, 1998.

Drug testing is a large part of the impaired physicians program. Participating physicians have to call an 800 number each day. The testing is by color identification; if a physician's color is up, they have to give a urine sample that day.

"The drug testing has been very effective for us," Dr. Martindale said. "We screen for all drugs, and if we see a pattern, we call the physician and talk to him."

Dr. Martindale sees the foundation as positive for everyone. From an economic angle it puts some "high-dollar" physicians, such as cardiologists, orthopedic surgeons and neurosurgeons, back to work. And getting these physicians back into their communities means more patients are getting better care, he said.

"Unless you've been close to it, you don't realize the impact of what happens to these physicians," Dr. Martindale said. "For a long time, this program was a real sale. We had to convince people, including other physicians, that this was a worthwhile program. We were losing doctors, and we just couldn't let it go on."

The program not only provides proper treatment for physicians, but it helps them get back to work and helps

"These are stories like mine — people who were on the bottom, but are now back in the community. But substance abuse is like an elevator — you can get off any floor you want. We used to think you had to go all the way to the bottom before getting off."

— Dr. Joe Martindale

hospitals get the doctors back on staff.

"Used to, at the hospitals, if there was a 'bad' doctor, he was ignored in hopes he would go away," Dr. Martindale said. "If they did confront the problem, the doctor wasn't welcomed back. Now the hospitals trust what we do. We've convinced them that we keep a handle on these doctors."

Hitting Rock Bottom

Often a community will ignore problems with a beloved physician, as in the case of Dr. Martindale.

"My community almost loved me to death," said Dr. Martindale, who also serves on the Benton School District School Board. "No one said anything about my drinking problem. They became enablers by not facing me with it."

Colleagues can be enablers, too.

"It's been the good ol' boy network," Dr. Martindale said. "We enabled our colleagues to continue rather than getting them help. But when it got too bad, we cast them away, taking their license. That's why, as a group, we really try to educate the medical community. We say, 'This is abnormal behavior, so let's confront it together.' " Dr. Martindale crashed in 1978, entering a residential treatment program in Little Rock soon after.

"I was working every day, drinking at night and taking pills during the day," he said. "Sooner or later, it gets to you."

He got involved in a 12-step program for alcoholics, and he and his wife still attend support group meetings with other physicians and their spouses.

"After my inpatient treatment it was time to go back to work, but no one was there to help me," he said. "I just didn't know if I could function as a physician again. It was scary to go in front of my peers and talk all this through with them. That's when I decided doctors needed an advocate."

For Dr. Martindale the nightmare ended. He started the recovery process, began working in the ER at Saline Memorial Hospital and joined a stable Benton practice. But for many without help, there's not much hope of getting back to where they were.

That's why the foundation has had so many success stories — because there was an advocate there for the physician who could help pave the way for a fresh start.

"These are stories like mine — people who were on the bottom, but are now back in the community," Dr. Martindale said. "But substance abuse is like an elevator — you can get off any floor you want. We used to think you had to go all the way to the bottom before getting off." ■

The Top 50

(Continued From Page 241)
medical students.

23. Operates a physician mentor program for medical students.

24. Participates in the policy-making process of the AMA through our three delegates.

25. Funds student representatives to the AMS and AMA House of Delegates.

26. Provides free membership to students, residents and new practicing physicians.

27. Cosponsors a one-day job fair for residents at the University of Arkansas for Medical Sciences.

28. Provides a physician referral service to the public.

29. Maintains a Web page, www.arkmed.org.

30. Conducts an annual meeting, which consists of educational programs and business meetings.

31. Invites medical specialty organizations to participate in annual meeting.

32. Conducts a biannual meeting of the House of Delegates to discuss legislative proposals.

33. Created Arkansas Health Care Ac-

cess Foundation to provide free health care to indigent.

34. Created Arkansas Medical Foundation to assist impaired physicians.

35. Created Medical Education Foundation for Arkansas to raise funds for education.

36. Provides management services for medical specialties.

37. Sponsors a political action committee to contribute to state and federal candidates.

38. Operates an accreditation program for intrastate sponsors of CME (only accredited sponsors can offer Category 1 credit).

39. Provides an annual conference for intrastate sponsors of CME.

40. Meets frequently with other state medical societies and AMA regarding issues and services.

41. Provides information and advice for members, office staff and the public on a broad range of topics including medical records, insurance, managed care, practice management, dismissing patients and closing a practice.

42. AMS staff and leadership attend county medical society and specialty so-

ciety meetings upon request.

43. Provides a peer review service for Medicaid.

44. Nominates member physicians for positions on the Arkansas State Medical Board, State Board of Health, Medical Care Advisory Committee (Medicare), Governors Medicaid Advisory Committee and other Boards and Commissions.

45. Bills and collects membership dues for county medical societies and the AMA.

46. Provides county medical societies with the names and addresses of physicians joining AMS directly so they may contact them about county membership.

47. Maintains knowledgeable legal counsel on retainer as a source of advice for physicians, their offices and the society.

48. Responds to and adjudicates complaints from patients against member physicians.

49. Provides meeting space for medical specialty society committee and board meetings.

50. Helps members and clinics resolve claim and/or policy disputes with Medicaid. ■

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Meet Our Members

Charles Lane Jr., MD

BY PATRICIA MAY

Dr. Charles Lane Jr.'s dreams of retirement were not unlike those of many people: days of leisure, travel and time with his family.

That's what Dr. Lane, a Fort Smith otolaryngologist who retired in 1986 after 36 years in private practice, and his wife, Evelyn, did.

But Evelyn's sudden death in 1993 changed all that. Dr. Lane admits he struggled for a time, not quite sure what to do with himself. The answer came through an invitation to attend a meeting of World Medical Mission in Asheville, N.C. Once there, Dr. Lane was certain he had found a new calling.

Since then, he's made three trips to Papua New Guinea, using his medical skills and sharing his religious beliefs, and he celebrated his 80th birthday there last May. God willing, he's planning a fourth trip to the hospital in 2000.

For his efforts, Dr. Lane recently was awarded the 1999 Award for Excellence in Medical Missions by the Samaritan's Purse, the arm of the World Medical Mission that helps temporarily place physicians such as Dr. Lane.

The award, known among mission doctors as the "Footsteps Award" (the full title is "In the Footsteps of the Great Physician") is given to a missionary doctor whose "example of humility, compassion and commitment to the Gospel has demonstrated to patients, colleagues, community and family members the love of God in Jesus Christ."

Papua New Guinea is a long way from Hattiesburg, Miss., where Dr. Lane grew up. He graduated from Tulane University School of Medicine and completed his residency at the Massachusetts Eye and Ear Infirmary in Boston. He thought he'd set up practice in Houston.

His good friend, Dr. Everett Moulton Jr., returned to his native Fort Smith to join his father's practice. Moulton Jr. was an ophthalmologist; his father was an eye, ear, nose and throat specialist. The elder Moulton decided to give up the ear, nose and throat portion of his practice, and the physicians invited Dr. Lane to join them.

"I flew down and spent a couple of days [in the area]," Dr. Lane recalls. "I was convinced Fort Smith was for me."

Dr. Lane opened his practice in January 1950, but eventually it became clear there was no ad-

vantage to combining the two specialties. The practices separated and Dr. Lane and Dr. Tom Raymond, also an otolaryngologist, moved to a new location.

The Western Arkansas Ear Nose and Throat Clinic, as it was known, eventually grew to become a four-physician practice, Dr. Lane says. Now it's part of the Cooper Clinic in Fort Smith.

When he retired in 1986, Dr. Lane did a couple of missionary tours with the Southern Baptist Foreign Mission Board. He spent a month in India in 1987 and went to St. Vincent Island in the southern Caribbean in 1989.

"Mrs. Lane and I thought it would wind up my mission work," he says. "What we were planning to do was some traveling and spending some time with our grandkids."

In August 1993, Evelyn Lane was diagnosed with lymphoma; she died four months later.

"After that, God really took hold of me," Dr. Lane says. "I felt a growing awareness that the Lord wanted me to get back into mission work."

Dr. Lane is planning a fourth trip to Papua New Guinea in 2000.

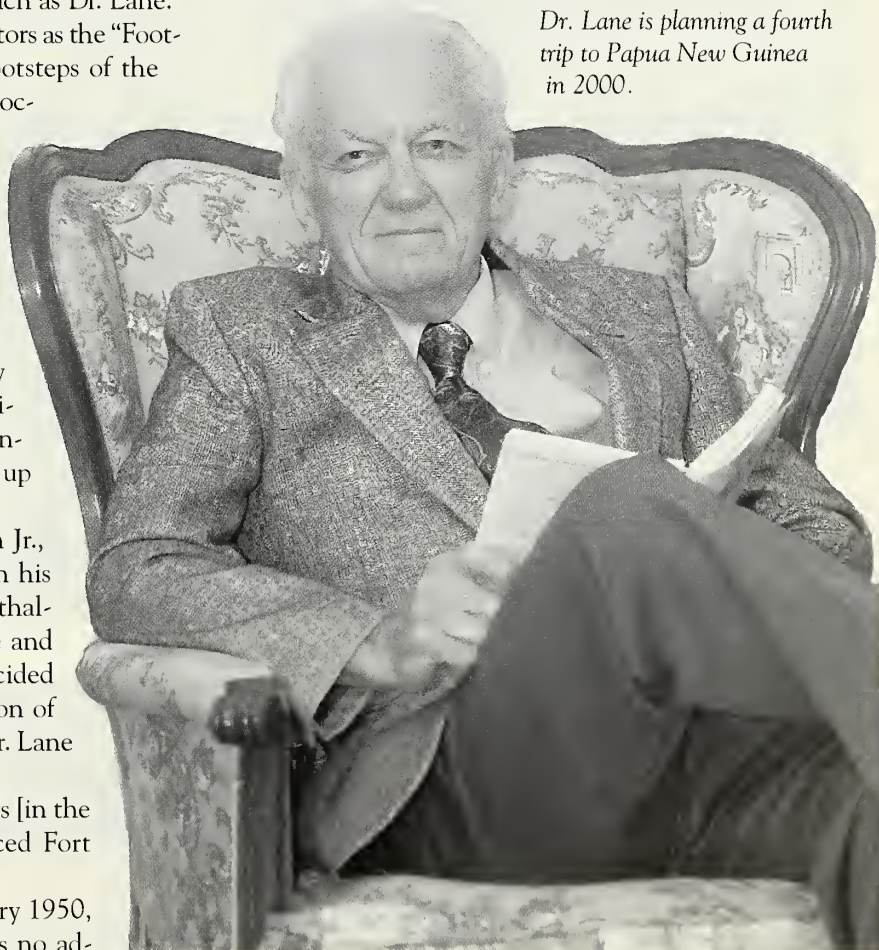


PHOTO: CARROL COPELAND

Samaritan's Purse is a nondenominational Christian evangelical group. It's part of a larger foundation, one headed by Franklin Graham, son of evangelist Billy Graham. Samaritan's Purse helps place physicians where they're needed, says spokesman Tom Layton.

Physicians usually are practicing and cannot become full-time missionaries, Layton says. The doctors pay their expenses, but Samaritan's Purse helps streamline travel arrangements, which can be complicated.

When he was invited to go to Papua New Guinea, Dr. Lane says he wasn't quite sure where it was. (It's north of Australia.) He still hasn't managed to master the language, Pok Pisin, which has about 75 dialects, but the hospital provides him with a staff member who interprets. As for witnessing his faith, Dr. Lane has become good friends with the hospital chaplain and often makes rounds with him.

A typical day at the Kudjip Nazarene Mission Hospital for Dr. Lane includes seeing about 30 patients. That

is, unless it's Wednesday, when the hospital's only operating room is reserved for Dr. Lane, who may do up to four procedures.

The hospital is modern and quite nice, Dr. Lane says, but there are no other specialists. In his field of otolaryngology, that's a problem because post-operative care is critical to many patients.

For that reason, Dr. Lane has become a missionary of another kind: He's trying to find other otolaryngologists willing to serve a few weeks at Kudjip. He's become a member of the Christian Society of Otolaryngology and has found at least one doctor who may travel to Papua New Guinea in 2000. Dr. Lane has delayed scheduling his own trip so it doesn't overlap with his colleague's.

Samaritan's Purse placed 228 medical personnel — 165 of them doctors; most of the rest were dentists — in more than two dozen countries in 1998. Layton says the missionaries often combine their work with

sightseeing or other travel experiences.

Dr. Lane, however, says he hasn't had time for that. He prefers to spend his time abroad using his skills.

The physicians usually file half-page reports with Samaritan's Purse after they return, Layton says. Dr. Lane, however, filed a 13-page detailed report after his last trip.

The living conditions are at least slightly primitive. Potable water, for instance, comes from rainwater that is collected from the buildings. It must be either boiled or chemically treated.

Still, Dr. Lane says he has managed to escape any stomach upset. He tries to stick to a daily exercise program of sit-ups and calisthenics.

Dr. Lane says he's willing and eager to talk to physicians who might be interested in participating in the Samaritan's Purse program.

"It's been a great experience for me," Dr. Lane says. "If I hadn't gotten into this, I don't know what I would have done. It's given me motivation, and I'm hoping to stay with it." ■

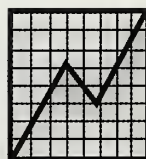
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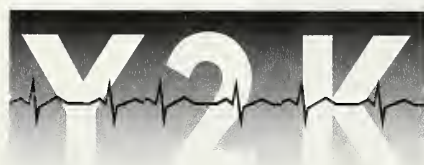
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“Lessons for the New Millennium From the Legacy of Country Doctors,” perhaps the first symposium of its kind honoring them, was held in Lincoln, Ark. Although not all-inclusive, the

lessons can guide us in Y2K. Surely, commitment, care, conviction and compassion, hallmarks of the country doctor, are basic concerns of any future doctor-patient relationship. Today’s care

A Legacy of the Country Doctors

ANTHONY T. DE PALMA, MD

is qualified as “managed care” but a lesson for the new millennium is “managed with care.” Other lessons learned include the importance of family, education, leadership and community involvement.

On Friday, May 14, 1999, a memorable millennium medical moment celebrating the Y2K legacy of the country doctors occurred in Lincoln. Physician Emeritus of Washington Regional Medical Center of Fayetteville met at the Arkansas Country Doctor Museum. The museum, founded in 1994 by Dr. Harold Boyer, of Las Vegas,

is one of two country doctor museums in the United States. Dr. Boyer honored his dad, Dr. Herbert Boyer, who was a country doctor in Lincoln.

The museum’s mission is eloquently stated: “The Arkansas Country Doctor Museum is committed to honoring, preserving and educating the public about the history and heroism of the country doctor in Ar-

kansas, the unique history and culture of the Ozark area and the history of medical theory and practice." It is in this spirit that Dr. Joe B. Hall "organized a special event for his colleagues in the Physician Emeritus group." The outcome, a symposium, "Lessons for the New Millennium From the Legacy of the Country Doctors," was presented by Physician Emeritus, Washington Regional Medical Foundation and the Arkansas Country Doctor Museum at the Lincoln Community Building.

Drs. Herbert Boyer, Edward Forrest Ellis, William Hugh Mock and P.L. Hathcock practiced in Washington County, and were honored at this historic event. Dr. Jack Wood spoke of recollections of his honored dad, Dr. Jesse Wood of Ashley County. The honored country doctors reflect a common concern of a noble, medical profession: commitment, care, conviction and compassion in alleviating mankind's ills and sufferings. Their dedication to patients and profession has been told in years of community service.

Dr. Herbert Boyer (Nov. 13, 1886-June 12, 1978) practiced for more than 60 years.

Dr. Edward Forrest Ellis (Aug. 18, 1863-Aug. 7, 1957) first practiced in Hindsville. He practiced there for 10 years and in 1896 moved to Springdale where he practiced until 1904 when he moved to Fayetteville. He practiced there until the time of his death.

Dr. William Hugh Mock (July 24, 1874-July 18, 1971) practiced a lifetime in Prairie Grove.

Dr. P.L. Hathcock (Dec. 31, 1878-Aug. 27, 1969) practiced in Harrison in 1901 and moved to Lincoln April 10, 1902. He moved to Fayetteville in 1921 and practiced until he was 83 years old.

Dr. Jesse Thomas Wood (Dec. 25, 1878-Sept. 8, 1969) practiced in his hometown of Fountain Hill about 10 years and in Crossett for about 10 years before returning to Fountain Hill in 1943 to resume practice until three years before his death.

Additional "Lessons for the New

Millennium From the Legacy of Country Doctors" are related in the following biographical excerpts:

The Lincoln Clinic started by Dr. Lacy Bean in 1936 evolved first as a maternity clinic and later an emergency center. Dr. Bean practiced here 10 years. Dr. Herbert Boyer, who practiced there until the early 1970s, followed him. Through the generosity of Dr. Boyer's son, Dr. Harold Boyer, a dermatologist, his Las Vegas colleagues and others, the Arkansas Country Doctor Museum came to fruition. Thus, the museum establishes continuity with the past, which is so important to the future of medical practice.

Long before
continuing medical
education became
mandatory, the country
doctor attended
postgraduate sessions
at metropolitan
medical meccas.

Dr. P.L. Hathcock followed the advice of his physician father, Dr. Alfred Monroe Hathcock, to settle in a small town and "work up." He practiced a short time with him in Harrison (U.S. Census 1900 population 1,517) after graduating from Vanderbilt University Medical School in 1901. As previously noted, he opened an office to practice in Lincoln (U.S. Census Star township [sic] population 728).

Long before continuing medical education became mandatory, the country doctor attended postgraduate sessions at metropolitan medical meccas. They knew the value of education for themselves, family and community. Apropos of medical education for men and women, "Women finally were accepted as full fledged medical practitioners in the nineteenth and twentieth centuries, but not without a struggle."

Dr. Ellis faced this discriminatory medical dilemma when a daughter declared an interest in becoming a doctor.

"Despite his love of medicine he did not see it as a proper occupation for women and absolutely forbid an older daughter, Martha, to enter medical school. However, by the time Dr. Ruth was ready to decide on a career, the world had changed and he encouraged her."² She graduated in 1933 from The Women's Medical College of Pennsylvania, formerly The Female Medical College of Pennsylvania. Legally organized in 1850, the medical school was the first one approved for women in the world.

Parallel Lives

Two of the honored country doctors, P.L. Hathcock and Jesse Thomas Wood, have significantly parallel lives reflecting the important legacy of family and education. Both were born the same year, 1878, six days apart and were raised in small towns. Both became country doctors and each had two sons who became physicians. Dr. P.L. Hathcock's sons, Preston Loyce and Alfred Hiram, became general practitioners with their father in Fayetteville. A son-in-law, Dr. Ralph E. Weddington, also practiced with them at the Hathcock Clinic. In 1957, Dr. Alfred H. Hathcock moved to Batesville, his wife Mary Louise Barnett Hathcock's hometown, to practice medicine. His son, Alfred Barnett, was an orthopedic surgeon specializing in hand surgery at the Holt-Krock Clinic in Fort Smith. Dr. Alfred Barnett Hathcock's son, Stephen, "Sixth Generation M.D. Blends Conventional Medicine with Alternative Remedies,"³ practices in Little Rock.

Dr. Jesse Thomas Wood's sons, Julian Deal and Jack Augustus, became general practitioners in Seminole, Okla. Jack left for a general surgery residency. Upon completion of his training, he joined Dr. J. Warren Murry in Fayetteville. Currently, Dr. Jack Wood's son, Stephen Thomas, a third-generation M.D., is following his father's footsteps as a general surgeon in Fayetteville. Dr. P.L. Hathcock and

Dr. Jesse Thomas Wood died 12 days apart in the same year, 1969.

Educators Among Us

Educational and leadership threads were woven in the country doctor's legacy to us. Among those contributing to their profession and community were Drs. Ellis, Mock and P.L. Hathcock. Drs. Ellis and Mock were both members of the Arkansas Board of Medical Examiners and presidents of the Arkansas Medical Society. Drs. Ellis, Mock and P.L. Hathcock were active on school boards. Dr. Ellis served 15 years on Fayetteville's school board and four years as chairman. Dr. Mock was president of the school board that built the first important school structure in the Prairie Grove district. Dr. P. L. Hathcock, at 18, was superintendent and taught at the Silver Rock school he attended as a child. When Dr. P.L. Hathcock practiced in Lincoln, he was a member of the county school board.

The venerable country doctor is remembered as having a one-on-one relationship with patients. However, he was also interested in community health and welfare. Dr. Harvey Doak Wood (Jan. 8, 1847-May 13, 1938) organized the Washington County Health Office in 1913 and was public health officer in 1913-1917. The importance of public health can be appreciated in a statement he made.

"May I mention but one instance of the progress in medical practice in the 62 years that has given more comfort and a higher appreciation of the greatest of all professions is the perfection of a diphtheria antitoxin that has saved the lives of millions of human beings."⁴

Incidentally, Dr. Wood was the 50th president of the Arkansas Medical Society; his patents included the Wood splint, a modification of the Hodgen splint with myodermic traction; and he coined more medical words than anyone else in his time. Dr. P.L. Hathcock also served as Washington County health officer for several years. With respect and deference to Dr. P.L. Hathcock, who did not like his initials spelled out, this author has refrained from doing so.

Fayetteville Ordinance 181 estab-

lished a city board of health in 1906. Dr. Andrew S. Gregg (1857-1938), a country doctor and two term city alderman, was a two-term city health officer at the time of his death. He also served on the Arkansas State Board of Health. Because of a national emergency in 1944 and being without a health officer, Ordinance 877 was passed and approved April 3, 1944, designating the mayor as health officer. Ordinance 881, recreating the separate office of city health officer and repealing Ordinance 877, was passed Aug. 21, 1944. The importance of a public health officer at the city and/or county jurisdictional level cannot be underestimated. "Continued economic and population growth in Northwest Arkansas is related to the pattern and standards of existing public health practice."⁵

"Lessons for the New Millennium From the Legacy of Country Doctors" fortunately have been recorded in literature, painting, poetry, radio and TV. Examples are: "Horse and Buggy Doctor," a historical account of the times, author Arthur E. Hertzler, M.D. (1870-1946), is the embodiment of a country doctor's life. The story was written in 1938. Milburn Stone, an actor who portrayed Doc Adams in the TV show "Gunsmoke," was asked to write the preface to the edition commemorating the author's 100th birthday:

"... For I feel certain that Dr. Hertzler was invited into heaven, where he can spend his time watching baseball games and sharpening his championship skill with a target pistol. Yet, he may have been offered an option. Perhaps, having conquered Kansas winters, he may have challenged hell. Possibly he is riding around that region in a battered old buggy drawn by an unpredictable horse, soothing the fevered inhabitants and calling the attention of Satan and his staff to the stupidity of attempting to standardize everything."⁶

Sir Samuel Luke Fildes' (1844-1927) painting, "The Doctor," exhibited in 1891 depicts a doctor seated near a sick child lying across two chairs at home. He is attentively observing her while the parents look on. "The Doctor" also captures a "house call" scene, which ultimately blossomed as

a "home health care" perennial.

"The Healer," a poem by John Greenleaf Whittier (1807-1892) to a young physician, with Dore's picture of Christ healing the sick, elicits a comment from Sir William Osler (1849-1919): "A well-trained sensible family doctor is one of the most valuable assets of a community, worth to-day, as in Homer's time, many another man. ..." ⁷ "Few men, live lives of more devoted self-sacrifice than the family physician."⁸

"Dr. Christian," airing 1937-1953, was the first radio medical soap later adapted to TV. Actor Jean Hersholt (1886-1956) played Dr. Christian, a humanitarian. "The good doctor was aided by his loyal nurse, Judy Price (Rosemary De Camp), who opened each show by picking up her phone with a perky, 'Dr. Christian's office!'" ⁹

Summary

Succinctly, lessons for the new millennium from the country doctors are embodied in their spirit. ■

References:

1. Lyons AS, Petrocelli, II, J. Medicine: An Illustrated History. "Women in Medicine," p. 565 Harry N. Abrams, Inc. New York, 1978.
2. Donat P. Dr. Edward Forrest Ellis. *Northwest Arkansas Times*, April 4, 1976.
3. Haman J. Changes in Attitude. UAMS Medical Center: Physicians Digest March/April 1999.
4. Fayetteville City Library: Grace Keith Genealogical Collection. Family Files.
5. De Palma, AT. NW Arkansas: Letter to the Editor. June 28, 1967.
6. Hertzler, AE. Horse and Buggy Doctor. Forward. p. x,xi. University of Nebraska Press, 1938.
7. Osler, Sir W. Aequanimitus and other addresses. xiv, p. 281. The Blakiston Co. NY.
8. Ibid p. 283.
9. Nachman, G. Raised on Radio. p. 379.

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CARDIOLOGY



The Waves of the Electrocardiogram: Part 3: The ST Segment

HANI A. RAZEK, MD — JOE K. BISSETT, MD — J. DAVID TALLEY, MD

This is the third article in a series of discussions reviewing the principle features involved in interpreting electrocardiograms (ECGs). In this article we will discuss the ST segment and its deviation in acute myocardial injury.

Patient Presentation

A 59-year-old female with long-standing systemic arterial hypertension presented to the emergency department with a sudden onset of substernal chest pain radiating to her left arm associated with dyspnea, palpitations, lightheadedness and diaphoresis occurring two hours prior to arrival (see Complete Problem List, Table 1). The patient was in moderate distress with persistent chest discomfort. The physical examination was unremarkable. The ECG (Fig. 1) showed sinus rhythm with inferior ST segment elevation and anterolateral ST segment depression consistent with an acute inferior wall myocardial injury with anterolateral ischemic changes. The patient underwent cardiac catheterization, which revealed a subtotal occluded right coronary artery with filling defect consistent with thrombus formation and a 80% distal occluded left anterior descending artery. Percutaneous coronary intervention was successfully performed to both le-

sions. The patient was discharged in stable condition.

Discussion

The ST segment lies between the final deflection of the QRS complex regardless of whether the final wave is an R or S wave and the beginning of the T wave. The ST segment represents the early phase of repolarization of the heart, which is the interval between the end of ventricular activation and the beginning of ventricular recovery. The ST segment is normally

isoelectric; this can be explained by the long plateau phase seen in repolarization of the ventricular cells, which is maintained by the slow calcium current. This creates a period during repolarization when most ventricular cells have approximately the same potential thus no current is generated. The point where the QRS complex ends and the ST segment begins is the J point. The length of the ST segment is influenced by factors that alter the duration of ventricular activation.

The first section of the ST seg-

Table 1. Complete Problem List

1. Systemic arterial hypertension
2. Coronary artery disease

Etiology: Atherosclerosis

Anatomy: A. Cardiac catheterization → 100% right coronary artery, 80% left anterior descending
B. Percutaneous coronary intervention → successful to the right coronary artery and left anterior descending

Physiology: Presentation with acute inferior myocardial infarction

Objective: Moderately compromised

Subjective: Mildly compromised

ment is normally located at the same horizontal level as the baseline formed by the PR segment. Slight elevation above the baseline as much as 1 mm in leads I, II and III and as much as 2 mm in the precordial leads and slight ST segment depression less than 0.5 mm in any lead are considered normal variant. Early ventricular repolarization that occasionally occur in young males can cause ST segment elevation as much as 1 mm in the direction of the following T wave. ST segment also may be altered during exercise or with altered sequence of activation of the ventricular myocardium.

Repolarization abnormalities are grouped into two general categories. First are the nonspecific ST changes, which include slight ST segment deviations that are considered normal variants but must always be interpreted in clinical context. Second are the ST segment changes that are relatively specific for an underlying cause. Examples of these are hypokalemia effect, digitalis effect, left ventricular hypertrophy, acute pulmonary infarction, acute pericarditis and myocardial ischemia. Unexplained ST segment elevation has been found in cases of acute cholecystitis, acute pancreatitis and bacterial shock.⁴

ST segment elevation is one of the earliest ECG signs of myocardial injury. It may be associated with or preceded by tall hyperacute T waves. Ischemic damage to the myocardium alters the sequence of ventricular activation and affects repolarization process of the heart, thus altering the electrical field of the heart and resulting in changes in the recorded electrical potential at various surface sites.

Injury creates a change in membrane integrity resulting in a change in membrane permeability to the flow of ions. The resting muscle during electrical diastole is relatively negative to the adjacent uninjured muscle, thus a flow of ions occurs between the injured and normal area and is called the injury current. The electric current flows away from the electrode, thus the ECG baseline is shifted

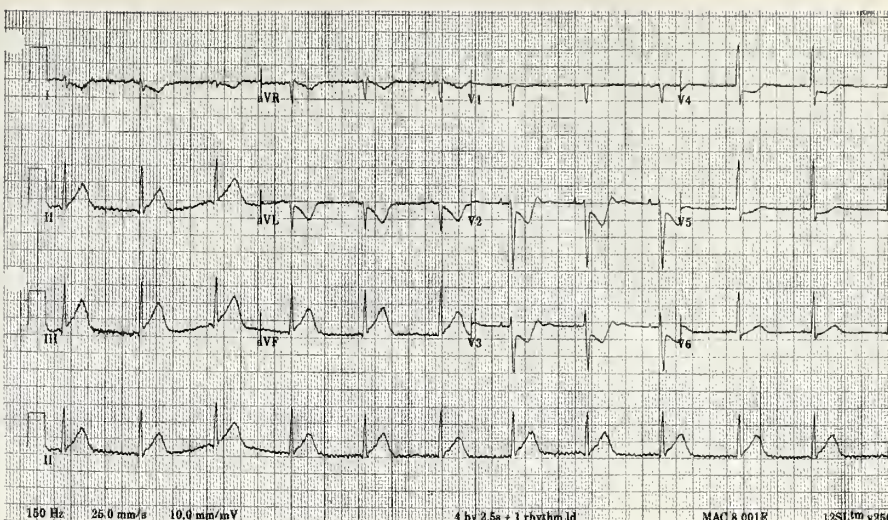


Fig. 1 The electrocardiogram shows sinus rhythm with significant inferior ST segment elevation and anterolateral ST segment depression consistent with an acute inferior wall myocardial injury with anterolateral ischemic changes.

downwards and is called injury deflection.¹

During electrical systole when the uninjured side of the injured muscle strip is stimulated and depolarization begins, an upward deflection is initially recorded representing the beginning of the QRS complex. When the stimulation reaches the negatively charged injured zone, no current flows and the deflection drops and rests on the original baseline forming the elevated ST segment. With initiation of repolarization, the tracing again drops to the injury deflection baseline. When the electrode is placed directly over the injured muscle, an elevated ST segment is recorded. When the electrode is separated from the injured muscle by uninjured muscle as in subendocardial injury, a depressed ST segment is recorded.²

Rapid decrease of ST segment elevation during an acute myocardial infarction is a predictor of coronary reperfusion, whereas recurrence of ST segment elevation suggests reocclusion.³ Patients with acute ischemic syndromes who have a normal electrocardiogram have a greater survival rate (94%) than that of patients with greater than 0.5-mm ST segment depression (70%). Thus, ST segment depression is an independent predictor of mortality in pa-

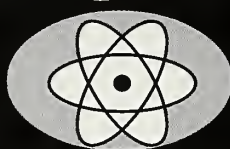
tients with acute ischemic syndromes.⁵ ■

References

1. Nahum LM, Hamilton WF, Hoff HE. The injury current in the electrocardiogram. *Am J Physiol* 1943; 139:202.
2. Cook RW, Edwards JE, Pruitt RD. Electrocardiographic changes in acute subendocardial infarction: I and II. *Circulation* 1958; 18:603.
3. Doevendans PA, Gorgels AP, et al. Electrocardiographic diagnosis of reperfusion during thrombolytic therapy in acute myocardial infarction. *Am J Cardiol* 1995; 75:1206.
4. Ryan ET, Pak PH, DeSanctis RW. Myocardial infarction mimicked by acute cholecystitis. *Ann Intern Med* 1992; 116:218.
5. Hyde TA, French JK, Wong C, et al. Four-year survival of patients with acute coronary syndromes without ST-segment elevation and prognostic significance of 0.5-mm ST-segment depression. *Am J Cardiol* 1999; 379-85.

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RADIOLOGY



Osteoporotic Compression Fracture With Persistent Pain

Treatment With Percutaneous Vertebroplasty

AUTHORS: STEVEN A. DUNNAGAN, MD — MICHAEL F. KNOX, MD — C. WILLIAM DEATON, MD

EDITOR: STEVEN R. NOKES, MD

An 82-year-old caucasian female with cryptogenic cirrhosis and colon carcinoma (in remission) fell in May 1999 breaking her wrist and developing severe back pain that did not resolve with bedrest and P.O. narcotic analgesia. She experienced progressive limitation of activity due to her back pain over several weeks. The pain was midline lumbar and exacerbated by all movement. No radiation to buttocks or lower extremities was described. Local tenderness to percussion over L2 and L4 was present at physical exam.

Plain films of the lumbar spine in June 1999 showed compression fractures at L2 and L4 (Figure 1a), which were subsequently confirmed at CT scan. No evidence of underlying destructive or inflammatory process was found.

On Aug. 3, 1999, the patient underwent percutaneous polymethylmethacrylate vertebroplasty at the L2 and L4 levels. The procedure was technically successful at both levels

with adequate filling of the vertebral bodies (Figure 1b). A small amount of epidural extravasation was noted at the L4 level which did not result in symptoms. The patient was observed in the hospital overnight and discharged the following day with significant relief of her back pain. Over the next several days she increased her activity to the premorbid level and discontinued use of all pain medications.

She remains pain free in the lumbar region four weeks after the procedure. She has discontinued all narcotic analgesia and is enjoying a normal activity level.

Percutaneous polymethylmethacrylate vertebroplasty was developed in the late '80s in France by Dr. Jacques Deramond primarily for use in malignant fractures of the spine. The dramatic effect on pain reduction in these patients led to its use in painful osteoporotic fractures. Drs. Jensen and Dion at the University of Virginia introduced the procedure in

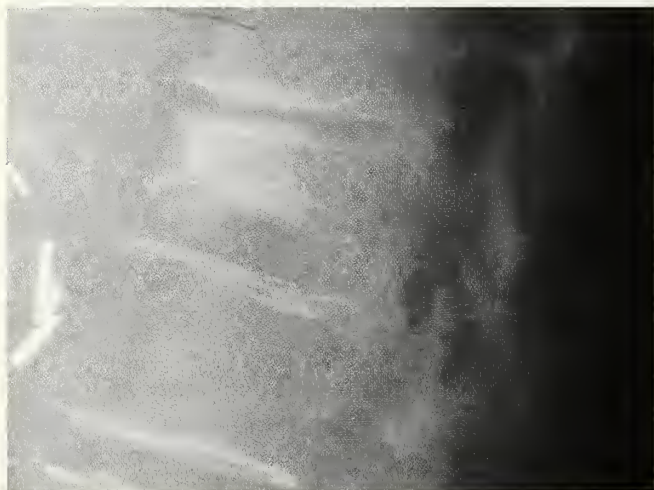


Figure 1a: Lateral pre-operative view of the L2 level showing greater than 50% collapse anteriorly. Sclerosis may indicate early healing, though patient's pain was still severe.



Figure 1b: Lateral post-operative view. Adequate filling of the marrow space with cement. Note filling of the needle track posteriorly (arrows).



Figure 2: A-P and lateral views showing needle in place at the L4 level of a patient with severe pain related to metastatic disease.

Note "cloud-like" expansion of cement around needle tip during injection.

the United States in 1992. Their initial experience with osteoporotic compression fractures was reported in 1997, and the procedure has since experienced rapid growth in the United States. Reported results from multiple centers continue to be excellent (80% to 90% success in significantly reducing pain, no major complications) as new programs have developed.

The procedure is performed by guiding a bone marrow trocar or biopsy needle into the affected vertebral body (Figure 2) via a trans-pedicular approach and injecting specially formulated polymethylmethacrylate (orthopedic cement) into the vertebral body thus stabilizing the fracture. There also may be a physical or toxic effect on local nerves that contributes to pain relief, which is usually immediate and dramatic. Conscious IV sedation is adequate for most cases, and it can be done as an outpatient procedure. The patient may return to normal activities the next day.

Serious complications are rare; none has been reported by properly trained individuals in the United States. Jensen's original article reports two rib fractures associated with the prone position required for the procedure. Venous intravasation of injected Polymethyl-methacrylate and small extravasations into disc space or epidural space are clinically inconsequential so long as large accumulations are avoided. Pulmonary embolization of polymethylmethacrylate related to vertebroplasty has been reported in one case with no adverse consequences to the involved patient. Infection has not occurred in the United States, but the French have had a small number of cases that responded to IV antibiotic therapy and did not require surgical intervention.

Approximately 15% to 20% of patients experience the occurrence of new fractures at new levels after successful treatment ("bounce back" fractures). The new fractures can be treated with vertebroplasty and similar results may be expected. It has been suggested that the procedure may predispose to the new fractures, but it seems more likely that the underlying osteoporosis remains the primary risk factor, and it has been shown that patients who suffer an initial vertebral compression fracture are at increased risk for development of new compression fractures in the absence of

vertebroplasty. It seems reasonable to state that vertebroplasty only results in new fractures to the extent that it relieves pain and returns the patients to normal activities.

Osteoporosis is a common affliction in our aging society, and the resulting fractures result in enormous economic and social consequences. Effective treatments are being developed, but it is unlikely that these therapies will solve the problem completely or in the near future. The current therapy for vertebral fractures consisting of bedrest, analgesics, physical therapy, medications to combat osteoporosis and bracing leaves much to be desired. Prolonged bedrest actually promotes calcium loss, bone resorption, and loss of muscle mass and may actually place the patient at higher risk for subsequent fractures. Vertebroplasty offers a safe and rapidly effective method for stabilizing vertebral fractures, reducing the debilitating pain associated with them, and returning the patients to premorbid activity levels. It is recommended as an excellent tool for patients not responding to conventional therapy. ■

References

1. Jensen M, Evans A, Mathis J, Kallmes D, Cloft H, Dion J. Percutaneous polymethylmethacrylate vertebroplasty in the treatment of osteoporotic vertebral body compression fractures: technical aspects. *AJNR* 1997; 18:1897-1904
2. Deramond H, et al. Percutaneous vertebroplasty with acrylic cement in the treatment of osteoporotic vertebral crush fracture syndrome. *Neuroradiology* 33: 149-152
3. Mathis J, Petri M, Naff N. Percutaneous vertebroplasty treatment of steroid-induced osteoporotic compression fractures. *Arthritis & Rheumatism* 1998; 1:171-175
4. Cotton A, Dewatre F, Cortet B, et al. Percutaneous vertebroplasty for osteolytic metastases and myeloma: effect of the percentage of lesion filling and the leakage of methylmethacrylate at clinical follow-up. *Radiology* 1996; 200:525-530
5. Ross P. Clinical consequences of vertebral fractures. *Am J Med* 1997; 103(2A):30S-42S



Morbidity and Cost of Vaccine-Preventable Varicella in Previously Healthy Children in Arkansas

MELINDA H. MARKHAM, MD
TONI DARVILLE, MD

Many physicians have not recognized varicella as a serious disease and are not advocating use of varicella vaccine. This retrospective study describes the morbidity and costs incurred by previously healthy children hospitalized at Arkansas Children's Hospital due to complications of varicella during a time period when an effective vaccine was approved for use. Fifty-five previously healthy children from 19 counties in Arkansas were hospitalized secondary to compli-

cations of varicella in the three years following release of varicella vaccine. Total numbers of hospital days for these patients were 192 with a cost totaling \$252,084. Increased efforts are needed to vaccinate the children of Arkansas against varicella.

Introduction

Varicella has long been considered a benign childhood disease in both the community and in the medical arena. Yet

complications of varicella, sometimes resulting in death, have been described. Varicella is currently the leading cause of vaccine-preventable deaths in the United States. Complications of varicella can be very serious, resulting in approximately 10,000 hospitalizations and 90-100 deaths per year, most of these in previously healthy children and adolescents.¹ In March 1995, the Food and Drug Administration approved the varicella vac-

cine. Soon thereafter, the American Academy of Pediatrics endorsed the universal use of the vaccine in both children and adults in the United States. This vaccine has been successfully used outside the United States for over 20 years, and seroconversion rates are reported to be greater than 90%.² Despite proven safety and efficacy, many physicians have been reluctant to use the vaccine. Concerns that have been expressed by physicians include waning immunity, cost of universal vaccination, and the belief that varicella is a benign disease.³ Another deterrent is the need for freezer storage of the vaccine. These issues have been thoroughly discussed in the medical literature, and the bulk of the evidence favors routine use of the vaccine.

Data from a National Immunization Survey conducted by the Centers for Disease Control in 1997 reported the varicella vaccination rate in Arkansas to be 16% among children aged 19-35 months, ranking our state 40th in the nation.⁴ Despite the approval and endorsement of this vaccine, pediatricians at Arkansas Children's Hospital continue to care for numerous children admitted due to complications of varicella. The purpose of our study was to detail specific complications and costs incurred by previously healthy children hospitalized due to complications of varicella. The cost of outpatient visits and medications, parental loss of work, and missed school days are not addressed. These factors increase the cost of this disease exponentially. As this study only reflects patients hospitalized at Arkansas Children's Hospital, it inherently underestimates the total number of children hospitalized in Arkansas with complicated varicella and the subsequent costs.

Methods

The protocol for a retrospective analysis of previously healthy children admitted to Arkansas Children's Hospital for complicated varicella was approved by the Institutional Review Board for Human Subject Research, University of Arkansas for Medical Sciences. Charts of patients admitted for complicated varicella in the three years following the re-

lease of the vaccine were reviewed. Patients were identified according to the computer database code for varicella as one of the admission diagnoses. Charts were reviewed for organ system affected, length of stay, vaccination status and demographics. Children who were immunocompromised or chronically ill (cystic fibrosis, underlying seizure disorder, trisomy 21, etc.) were omitted. The cost of each hospitalization was obtained from patient records in accounting.

Results

Over the 36-month period, there were 55 children admitted to Arkansas Children's Hospital for complicated varicella. Their ages ranged from 1 month to 15 years, with a median age of 2.1 years. These patients resided in 19 different coun-

Table:
Complication of Varicella by Organ System

Site	No.	% of Patients
Cellulitis	33	60
Sepsis, sepsis syndrome	4	7.3
Necrotizing fasciitis	1	1.8
Dehydration	13	23.6
Neurologic	10	18.2
Pulmonary	5	9.1
Hepatitis	2	3.6

ties in Arkansas. No child had received the varicella vaccine. Fifty of the 55 patients were less than 1 year of age and, therefore, eligible to receive the vaccine.

The most common complication was cellulitis, found in 33 of the 55 patients (Table). Specific sites of cellulitis included 10 cases with preseptal cellulitis and 6 with facial cellulitis. There were 3 cases of cellulitis/adenitis, one requiring airway monitoring in the Pediatric Intensive Care Unit. Two patients had cellulitis of the chest, one of the abdomen, and one of the chest and abdomen. Eight other patients had cellulitis surrounding local lesions on their extremities requiring intravenous antibiotics. One patient had septic arthritis of the elbow, requiring surgical drainage and long-term antibiotics.

Three patients with cellulitis had

documented bacteremia, two with Group B-hemolytic *Streptococcus* (GABHS) and the other with Group D *Streptococcus*. Two of them had no signs of sepsis. However, one 4-year-old boy with fasciitis of the abdomen, left flank and left thigh developed septic shock and disseminated intravascular coagulation secondary to GABHS. This patient required mechanical ventilation for 2 days and was managed in the PICU. He received multiple transfusions of blood products (packed red blood cells, fresh frozen plasma and platelets). He also required inotropic support with two agents for treatment of hypotension. Other complications of his 15-day hospitalization included a pleural effusion and an upper gastrointestinal bleed. Three other patients with cellulitis had systemic inflammatory response syndrome without a positive blood culture. Two of the patients required fluid resuscitation only, and the third required both fluid and inotropic support.

Besides cellulitis, other complications included dehydration, transient neurological abnormalities, pulmonary complications, and hepatitis (Table). Of the patients with neurological complications, three had mental status changes, one of which had hallucinations attributed to antihistamine toxicity. Seven had seizures or seizure-like activity. Four of these patients were felt to have febrile seizures. Studies performed include computed tomography of the head (5), electroencephalogram (2), and cerebrospinal fluid exam following a lumbar puncture (6). All of these studies were normal. All 10 patients had resolution of symptoms prior to discharge. Of the patients with pulmonary complications, three were diagnosed with pneumonia. Two had pleural effusions secondary to chest wall cellulitis in the absence of clinical or radiographic evidence of pneumonia. Thirteen patients had multi-organ involvement. None of the 55 patients died.

The median length of stay in the hospital was two days, with a range of 1-15 days. There were a total of 192 hospital days for these patients. Their hospital costs accumulated to \$252,084. The charges ranged from \$810 to \$34,103, with a median cost of \$2,879. In Arkan-

sas the average cost of the varicella vaccine in a private office is \$60; therefore, 4,200 children could have received the vaccine for the price of hospitalization of these children. If this calculation is made using federally sponsored vaccine programs and their cost to the state of Arkansas, more than 84,000 varicella immunizations could have been administered.

Discussion

Although varicella can be an uncomplicated disease in many children, the above data support the need for vaccination against this disease in our state. Although no child in this study died of complications, there have been deaths in previously healthy children due to complications of varicella at our institution. Specific complications found in our study mirror those reported in other studies around the nation.^{5,6} The most common complication is that of secondary bacterial skin and soft tissue infections, with extracutaneous complications of varicella being less common. The most severe form of skin infection is that caused by invasive GABHS which can lead to the "flesh-eating bacteria syndrome," or necrotizing fasciitis, and/or toxic shock. Both disease processes were demonstrated in our 4-year-old patient described above. In a 5-year review from Canada, it was found that children with varicella were 58 times more likely to develop GABHS infection than children without varicella. In their patients who had GABHS infection and varicella, 19% had necrotizing fasciitis and 3% died. They determined that for every 100,000 children who have varicella, five will develop invasive disease due to GABHS.⁷ Thus, if the hospitalization costs accrued in this study could have been utilized toward vaccination, four cases of GABHS infection may have been potentially prevented.

Vaccination against varicella provides protection even with household exposure (70%) and increased protection against severe varicella disease (95%).⁸ No evidence of waning immunity has been documented in follow-up studies of healthy children 6-10 years after vaccination.¹ Another issue of concern is the rate of zoster after vaccination. However,

current evidence shows that persons who receive the vaccine are less likely to develop zoster than those who had natural disease.⁹ Recent cost-benefit estimations report savings of \$399 million annually with universal varicella vaccination.¹⁰ Despite overwhelming evidence of safety and efficacy, the varicella vaccine is poorly utilized. Therefore, in February 1999, the Advisory Committee on Immunization Practices recommended that states require varicella vaccination for entry into child care facilities and elementary schools.⁴ A bill passed by the Arkansas legislature in 1997 required the immunization of children against varicella prior to entering kindergarten, and guidelines for instituting the requirement of proof of vaccination for entry into child care facilities in children over one year of age are being formulated. Because most children develop varicella disease between the ages of 1-6, it is imperative that Arkansas physicians immunize their patients as soon as they are eligible (12 months of age).

Clinical varicella continues to be a problem in Arkansas. Parents may be unaware of the vaccine, and many physicians still consider it optional. Varicella vaccine is now a part of the Recommended Universal Immunization Schedule as approved by the ACIP, AAP, and the American Academy of Family Physicians. In the first two years following its release, the vaccine had limited availability in Arkansas Health Department offices due to the need for freezer storage. In the last 18 months, this problem has been remedied, and the vaccine is now stocked in all health department offices in the state. All logistic roadblocks to use of the vaccine (approval, availability, and funding) have been removed in Arkansas. The above data should further dispel the myth that varicella is a benign disease, urging implementation of the official recommendation for vaccination against varicella. ■

References

1. Centers for Disease Control and Prevention: Prevention of Varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 45(No. RR-

- 11), 1996.
2. Johnson CE, Stancin T, Fattlar D, Rome LP, Kumar ML: A long-term prospective study of varicella vaccine in healthy children. *Pediatrics* 100:761-766, 1997.
3. Schaffer SJ and Bruno S: Varicella immunization practices and the factors that influence them. *Arch Pediatr Adolesc Med* 153:357-362, 1999.
4. Centers for Disease Control and Prevention: Prevention of Varicella: Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 48 (No. RR-06):1-5, 1999.
5. Peterson CL, Mascola L, Chao SM, Lieberman JM, Arcinue EL, Blumberg DA, Kim KS, Kovacs A, Wong VK, Brunell PA: Children hospitalized for varicella: a pre-vaccine review. *J Pediatr* 129:529-536, 1996.
6. Aebi C, Ahmed A, Ramilo O: Bacterial complications of primary varicella in children. *Clin Infect Dis* 23:698-705, 1996.
7. Laupland K, Davies HD, Low DE, et al: Does Varicella-Zoster Virus (VZV) infection predispose to invasive or severe invasive Group A streptococcal (GAS) infection? Evidence from population-based surveillance in Ontario. Presented at the 38th Interscience Conference on Antimicrobial Agents and Chemotherapy. Sept. 24-27. San Diego.
8. Committee on Infectious Diseases: Recommendations for the use of live attenuated varicella vaccine. *Pediatrics* 95:791-796, 1995.
9. Gershon A, Silverstein S: Live attenuated varicella vaccine for prevention of zoster. *Biologicals* 25:227-230, 1997.
10. Lieu T, Cochi SL, Black SB, et al: Cost-effectiveness of a routine varicella vaccination program for US children. *JAMA* 271:375-381, 1994.

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Perils of Ignoring the Family

J. KELLEY AVERY, MD

Because of the obvious negligence on the part of the ED physician in giving Thorazine, which is known to reduce the threshold for seizure activity, experts were not to be found that would support this treatment.

A 24-year-old woman, married for four years, had her first seizure since her marriage and was taken to the emergency department of a medical center hospital. Her husband had never witnessed a seizure before this one, and her mother was the primary historian.

The patient had a history of seizures since she was 13 years of age that had been controlled on combined therapy of Tegretol and Mysoline. She had been the patient of the same neurologist since that time. She had experienced three generalized tonic-clonic episodes, one of which was followed by a long postictal phase and complicated by a left hemiparesis that cleared completely prior to her discharge from the hospital. On that admission she had a complete neurologic workup, including MRI and EEG, without evidence of neurologic abnormality.

On this occasion the patient had a severe grand mal seizure that lasted about 10 to 15 minutes. On arrival, the triage nurse noted the history and that she was drowsy but cooperative, and that her neurologic examination was normal. She was seen promptly by the ED doctor, and his assessment also showed no neurologic abnormality. He ordered blood levels of both the Tegretol and Mysoline, routine blood screens, chest X-ray and CT of the head without contrast. After writing the orders, the doctor left the room to see other patients. The patient then began to have another seizure, and the physician was called back into her room. After a brief evaluation by the doctor she received Phenergan, Vistaril and 50 mg of Thorazine. Although it is not well documented, the physician apparently thought that his patient was hyperventilating. Within minutes of the administration of the medication, the seizure began again. The patient's mother and husband asked that the attending neurologist be called at this time, but the ED physician reassured them that he could handle the situation.

Confronted with this refusal to call the specialist, the patient's husband called the doctor's answering service and asked that he be allowed to talk to the neurologist. He was informed that only another physician would be put through to the specialist.

When the patient did not respond to stimulation after the second seizure, the neurologist had been called and had ordered that the patient be admitted to the neurology floor. He did not come in to the hospital for about two hours, and when he did come, he transferred his patient to the Neurology Intensive Care Unit. At this time, about eight hours after admission to the ED, the husband and mother were called in to the patient's room and told that it did not look like the patient would "make it."

After admission to the unit, blood gasses revealed a Po of 69% and O₂ saturation of 87%. Shortly after she began receiving oxygen and was incubated, the O₂ saturation was 94%. She remained comatose, however, and it soon became apparent that she was quadriplegic. She was aggressively supported and gradually regained consciousness but was left paralyzed.

After months of physical therapy in a neurologic rehabilitation center she regained some use of her left arm. When she achieved maximum recovery, she was alert, normally responsive and conversational but remained totally dependent on her family for care and support.

A lawsuit was filed charging the ED physician with negligence for not calling the attending neurologist, for giving Phenergan and Thorazine and for overall negligence in not providing the patient with care that met an acceptable standard. Even though the neurologist was not summoned by his answering service on request of the patient's husband, he was not sued because the husband and mother considered that once on the scene, he was thorough and compassionate.

The issue of his responsibility for the actions of his answering service in shielding him from his patients was not a factor.

Because of the obvious negligence on the part of the ED physician in giving Thorazine, which is known to reduce the threshold for seizure activity, experts were not to be found that would support this treatment. The case had to be settled for a very large amount.

Loss Prevention Comments

Acting on the assumption that the patient was hyperventilating and hysterical, and ignoring the history as recounted by both the patient's mother and husband, the ED physician gave medication known to be contraindicated. The temporal relationship between the administration of the medication and the onset of the severe seizure activity, which deprived the patient of adequate oxygen and resulted in the paraplegia, was a matter of

record and could not be contested. He ignored the pleas of the family to call the neurologist while the patient was still in the ED, and very soon after, it was apparent that the patient was not returning to consciousness as expected. Nurses in the ED were critical of the doctor for not starting O₂ promptly on learning of the low levels of the Po and the O₂ saturation and for not calling the specialist to come in to the ED to evaluate his patient.

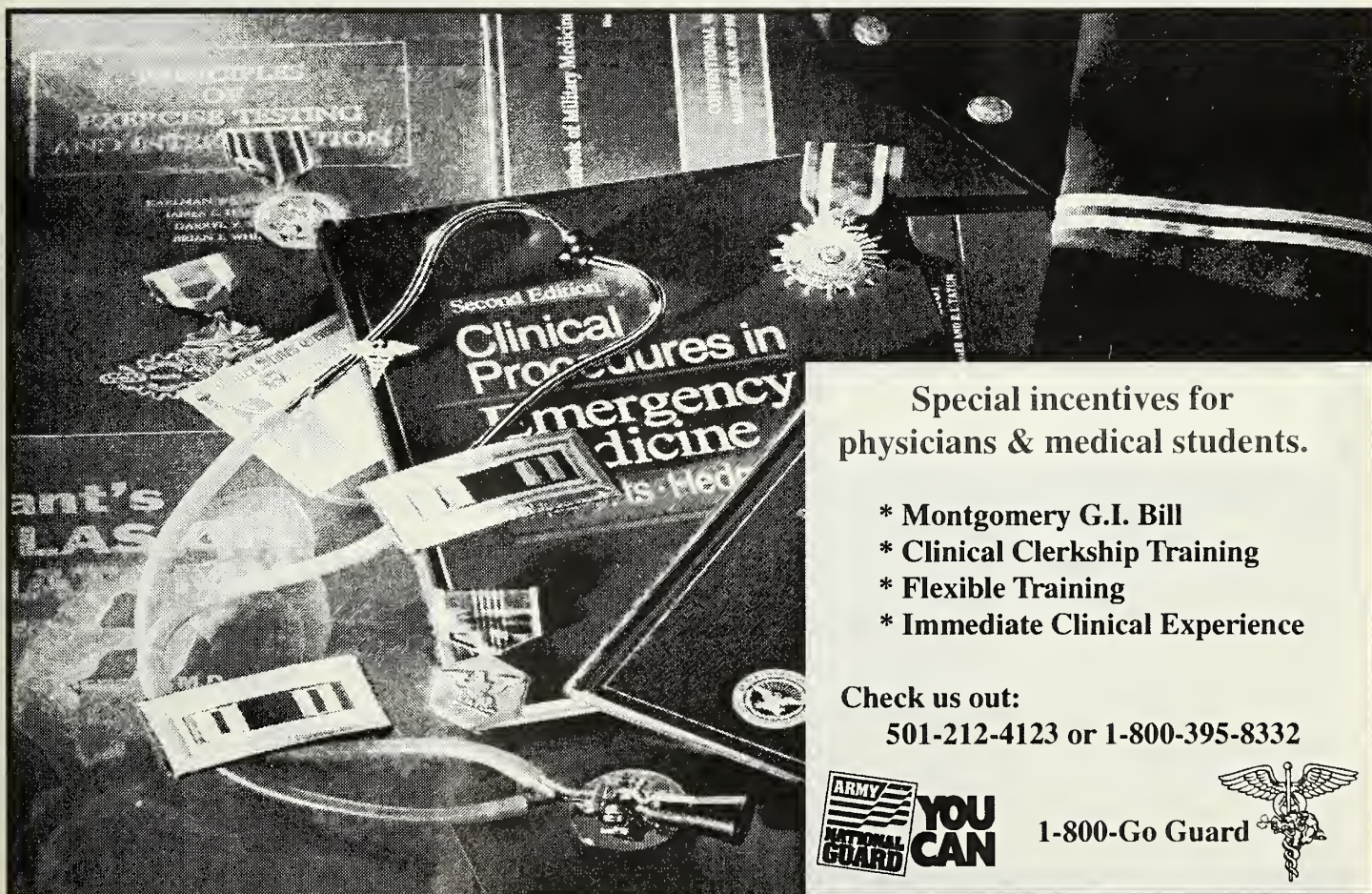
Contributing greatly to the decision to settle this case was the fact that the mother and husband were such credible witnesses on deposition. Their stories were objective and believable. Also, the patient herself was compelling and, according to the defense attorney, "the jury will fall in love with her."

The lesson to be learned here is that the history in most cases is enhanced by the family, and the physician's understanding of the

patient's problem is increased. The ED physician would not have given the contraindicated medication if he had listened to the patient's history of a seizure disorder that had been present since adolescence. This appreciation of the significance of the history would have greatly militated against the diagnosis of hyperventilation for which he gave that medication. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.



Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the January 1999 issue of Tennessee Medicine. It is reprinted with permission.



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HONORED

Boozman-Hof Center Earns Allergan Honor

The Boozman-Hof Regional Surgery and Laser Center in Rogers recently was named an Allergan Center of Excellence by Allergan Inc., an eye care company based in Irvine, Calif.

Three other clinics in the United States have earned the title, which is based on criteria such as the use of cutting edge techniques and having a surgical center.

"The Boozman-Hof Eye surgery and Laser Center is the finest surgical center I've seen in the country," said Richard Lynn, Allergan area spokesman.

"This is an extremely prestigious honor and it says to our profession that the world's second-largest eye care company considers Boozman-Hof Surgery and Laser Center to be one of the finest in the country — something we already knew," said Dr. Randall Cole, the center's primary refractive surgeon.

Dr. Chambers Claims Two UAMS Awards

Dr. Carlton L. Chambers III, an assistant professor in the department of otolaryngology at the University of Arkansas for Medical Sciences, recently won two awards.

He is one of the UAMS faculty members picked by the 1999 graduating class to receive the Red Sash Award, based on a high interest in stu-

dents and time spent teaching, encouraging and training.

Dr. Chambers also won the Otolaryngology Teaching Award, chosen by residents at UAMS.

Dr. Sessions Receives Award From AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

The AMS recipient for October is Dr. Louis Walker Sessions of Little Rock.

LECTURES

Dr. Ackerman Lectures on Sympathetic Pain

Dr. William E. Ackerman, III, a pain medicine physician in Little Rock, lectured about his research on upper extremity sympathetic pain at the American Academy of Disability Evaluating Physicians in Tucson, Ariz., in November.

Dr. Ackerman also lectured on whiplash pain management at the World Congress on Pain in Vienna and presented two abstracts at the American Society of Regional Anesthesia annual meeting in Philadelphia earlier this year.

He was a co-investigator on a paper presented at the American Society of Anesthesiology meeting in Dallas and another at the International Anesthesia Research Society annual meeting in San Diego.

UAMS Students Earn PCMS Scholarships



Left to right: Denise R. Greenwood, MD, with PCMS scholarship winners Laura Cupples, Heather Diemer, Owen Middleton and Amy Warriner.

The Pulaski County Medical Society Board of Directors awarded scholarships to four sophomores at the University of Arkansas for Medical Sciences during the annual College of Medicine Scholarship Banquet at Arkansas' Excelsior Hotel.

The recipients are Laura Cupples and Owen Middleton of North Little Rock, and Heather Diemer and Amy Warriner of Little Rock.

The PCMS scholarship program, which began in 1983, offers benefits based on scholastic achievement, leadership potential and financial need.

OBITUARY

Dr. Walter J. Wilkins, 80, of Pine Bluff died Oct. 9 in Fayetteville.

He was a general surgeon from 1951-86 in Pine Bluff and was director of medical affairs at Jefferson Regional Medical Center, 1986-92.

The Pine Bluff native was a graduate of Washington and Lee University in Lexington, Va., and Johns Hopkins Medical School. He served in the Army Medical Corps from 1945-47 and completed his surgical residency at Presbyterian-St. Luke's Hospital and Cook County Hospital in Chicago.

Dr. Wilkins also served as an associated professor at the University of Arkansas for Medical Sciences, and was chief of surgery and chief of staff at JRMC.

Survivors include his wife, Genevieve "Gen" Kennedy Wilkins, a son and a daughter. ■

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Chalfant, Paul
Chism, Brandon
Citty, James
Clingan, Warren
Cook, Michael
Covert, Kent
Craig, Jennifer
Crowd, Matthew
DaVeiga, Adriana
Daugherty, Jeremy
Denton, Meredith
Dickinson, Jacob
Dopkou, Joshua

**Resident/Intern

CALENDAR

Feb. 7-9, 2000

Rural Health Policy Institute

The National Rural Health Association has scheduled the Rural Health Policy Institute Feb. 7-9 at the Washington Court Hotel in Washington, D.C. For more information, call (202) 232-6200 or visit www.nrharural.org.

March 30-April 1, 2000

Conference on Legal Medicine

The American College of Legal Medicine is sponsoring a Conference on Legal Medicine March 30-April 1 at the San Diego Hilton Beach and Tennis Resort in San Diego, Calif. The conference will highlight pressing medical issues facing the medical and legal professions. Contact the ACLM at (800) 433-9137 or e-mail at info@aclm.org for more information.

April 13-15, 2000

Federation of State Medical Boards Annual Meeting

The annual meeting of the Federation of State Medical Boards will be April 13-15 in Dallas. For more information, call (817) 868-4007 or visit www.fsmb.org.



May 5-6, 2000 Arkansas Medical Society Annual Meeting

The Arkansas Medical Society will hold its 124th annual meeting May 5-6 at the Embassy Suites Hotel in Little Rock.

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Arkansas Medical Society

1999 Membership Roster

American Medical Association Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Arkansas Medical Society 1999 Membership Roster

As of Nov. 3, 1999

Denotes deceased member

Please Note: If you cannot find a particular physician in the county listings, look under the Direct Member Section beginning on page 282. Direct Member indicates AMS members who are not members of their county medical society or whose county membership was pending at the time of this journal's printing.

Arkansas County

Burleson, Stan W.
Chavin, Michael A.
Daniel, Noble B. III
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Millar, Paul H. Jr.
Morgan, Jerry D. #
Northcutt, Carl E.
Pritchard, Jack L.
Speer, Hoy B. Jr.
Speer, Marolyn N.
Tracy, W. Lee
Wood, Gary P.
Yelvington, Dennis B.

Ashley County

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Garcia, Luis F.
Gresham, Edward A.
Heder, Guy W.
Henry, William Jr.
Rankin, James D.
Salb, Robert L.
Thompson, Barry V.
Toon, D. L.
Walsh, Benjamin J.
Wilson, Alan K.

Baxter County

Adkins, Kevin J.
Baker, Robert L.
Barker, Monty
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Chatman, Ira D.
Cheney, Maxwell G.
Chock, Daniel P.
Clarke, James S.
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Douglas, Donald S.
Dyer, William
Dykstra, Peter C.
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Foster, Robert D.
Hagaman, Michael S.
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Hodges, Michael E.
Johnson, Stacey M.

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Kerr, Robert L.
Kilgore, Kenneth M.
Knox, Thomas E.
Landrum, William
MacKercher, Peter A.
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McAlister, Matthew
McBride, Anthony D.
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Regnier, George G.
Rigler, Wilson F.
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Stahl, Ray E. Jr.
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Trager, Marc
Tullis, Joe M.
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White, Richard B.
Wilbur, Paul F.
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Black, Randall Wayne
Bledsoe, James H.
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Cole, Randall E.
Compton, Neil E. #
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Cuchia, John

Dang, Minh-Tam
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Diacon, W. Lindley
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Ewart, David
Fangmeier, Angela Anne
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Friesen, Douglas L.
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Harmon, Harry M.
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Hill, Joy
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Hof, C. William
Holder, Robert E.
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Hull, Robert R.
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Johnson, Royce Oliver II
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Low, Lisa
Lueders, Andrew J.
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McKnight, William D.
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Ritz, Ralph C.
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Smith, Robert B.
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Summerlin, William T.
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Vanderpool, R. Douglas
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Youngblood, Thomas

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 Crain, Vance J.
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 Rindt, Phillip Lee

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 Hejmej, Ryszarda M.
 Masquil, Filipe
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 Savu, Calin A.
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 Turney, Lonnie R.
 Young, James E.

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 Maxwell, Ralph M.
 McKiever, William R.
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 Wallick, Paul A.
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 Wilson, Harold F.

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 Bowlin, Randal
 Bowman, Gary
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 Cheek, Ben H.
 Cole, Andrew
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 Connaughton, Michael A.
 Cummins, J. Craig
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Dodge, Ben
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 Garrison, James S.
 Ghormley, J. Tod
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 Hendrickson, Richard O. Jr.
 Hudson, Thomas F. III
 Jackson, Carole
 Landberg, Karl H.
 Landgren, Robert C.
 Lewis, Gregory
 Magie, Jimmie J.
 Martin, David A.
 McCarron, Robert
 McChristian, Paul L.
 Murphy, Kenneth
 Naylor, David L. Jr.
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 Raney, Herschel D. Jr.
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 Tsuda, Sue

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 Richter, David A.
 Sico-Davis, Chrisandra R.
 Smith, John C.
 Wilson, Robert

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 Agee, Kimberly R.
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 Bodemann, Michael C.
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 Braley, Richard E.
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 Clardy, William F.
 Corbitt, Mark A.
 Cupp, Cecil W. III
 Davis, Katrina
 Davis, Sheryl L.
 Dodd, Lawrence
 Dodson, John W. Jr.
 Dolan, Patrick III
 Drake, Gary M.
 Dunn, Richard W.
 Dykman, Kathryn
 Eisele, W. Martin
 English, P. Timothy
 Erwin, John
 Finch, Richard R.
 Fine, B.D. Jr.
 Fore, Robert W.
 Fotioo, George J.
 Fraiss, Michael A.
 French, James H.
 Gardner, James L.
 Garrett, W. Michael
 Gerber, Allen D.
 Gocio, Allan C.
 Griffin, James E.
 Grose, Andrew
 Haggard, John L.
 Hale, Kevin D.
 Hardy, Ross A.
 Harper, Edwin L.
 Harrison, Jack W.
 Headrick, Daniel
 Hechanova, D. M. Jr.
 Heinemann, Fred M.
 Heinemann, Phyllis E.
 Henderson, Francis M.
 Herrold, Jeffrey W.
 Hickman, Michael P.
 Hill, H. Randy
 Hill, Robert L.
 Hitt, W. C. Jr.
 Hollis, Thomas H.
 Howe, H. Joe
 Hughes, James A.
 Hulsey, Matthew

Humphreys, Robert P.
 Hunter, Karla
 Irwin, William G.
 Jackson, Brian D.
 Jackson, Haynes G.
 Jackson, Haynes G. Jr.
 Jayaraman, K. K.
 Jayaraman, Vilasini D.
 Jayne, Russell P.
 Johnson, Paulette S.
 Johnson, Robert D.
 Johnston, Gaither C.
 Josef, Stanley
 Kaler, Ron A.
 Keadle, William R.
 Kincheloe, A. Dale
 Kleinhenz, Robert W.
 Klugh, Walter G. Jr.
 Koehn, Martin A.
 Lagaly, William J.
 Larey, Mark E.
 LeMay, Thomas B.
 Lee, Allen R.
 Lee, William R.
 Longo, Margaret F.
 Martin, Jana
 Maruthur, Gopakumar
 Mashburn, William R.
 McClard, Helen
 McCrary, Robert F. Jr.
 McFarland, Louis R. #
 McFarland, Mike S.
 McMahan, James
 Meek, Gary N.
 Mullins, Michael
 Munos, Louis R.
 Olive, Robert Jr.
 Padmini, Rangaswami
 Pai, Balakrishna
 Pappas, Deno P.
 Parkerson, Cecil W.
 Peeples, Raymond E.
 Pellegrino, Richard
 Plaza, Jesus A.
 Powell, Brenda
 Queen, George P.
 Rainwater, W. Sloan
 Raney, Amanda B.
 Raney, Jerel L.
 Reddy, Prabhakara K.
 Robbins, Mark
 Robert, Jon M.
 Rogers, Marc
 Roper, Richard
 Rosenzweig, Joseph L.
 Russell, Mark
 Sanders, Hallman E.
 Seifert, Kenneth A.

Sharma, Bimlendra
 Shelby, Eugene M.
 Shroff, Rajesh K.
 Simpson, John B.
 Slagle, Gregory S.
 Slaton, G. Don
 Sloand, Timothy Peter
 Smith, Bruce L. Jr.
 Smith, John W.
 Smith, Phillip L.
 Sorenson, Marney K.
 Sorrels, John W.
 Sousan, Leo
 Springer, Melvin R. Jr.
 Springer, William Y.
 St. John, Greg
 St. John, Melody
 Stecker, Elton H. Jr.
 Stecker, Rheeta M.
 Stough, D. Bluford III
 Tangunan, Priscilla L.
 Tapley, David R.
 Thomas, W. Al
 Tucker, R. Paul
 Vallery, Samuel W.
 Vogel, Eric D.
 Wagenhauser, Karl F.
 Wallace, Thomas "Tom"
 Walley, Luther R.
 Warren, E. Taliaferro
 Warren, William Jr.
 Watermann, Eugene
 Waters, Samuel
 Webb, Timothy
 Woodward, Philip A.
 Wright, Charles C.
 Young, Michael J.

Grant County

Heise, Brian A.
 Irvin, Jack M.
 Paulk, Clyde D.
 Winston, Scott D.

Greene-Clay County

Baker, Clark M.
 Blair, Donald Waring
 Boggs, Dwight F.
 Bonner, J. Darrell
 Brown, Howard Stanton
 Bulkley, William J.
 Burchfield, Samuel S.
 Cagle, Roger E.
 Collier, Jon D.
 Crow, Asa A.
 D'Anna, Richard E.
 Duckworth, Hillard R.
 Fonticiella, Adalberto

Hardcastle, R. Lowell
 Hazzard, Marion P.
 Hendrix, Barry
 Hendrix, Lisa
 Hobby, George A.
 Ilyas, Mohammad
 Jackson, Ron
 Kemp, Clarence
 Lawson, J. Larry
 Luker, Jerome H.
 Martin, Richard O. #
 Mitchell, Bennie E.
 Morrison, Jimmy J.
 Muse, Jerry L.
 Nissenbaum, Eliot M.
 Page, Billie C.
 Purcell, Donald I.
 Rich, Cheryl Darline
 Rouse, Kevin
 Shedd, Leonus L.
 Sheridan, James G.
 Shotts, C. Mack Jr.
 Shotts, Vern Ann
 Smith, Norman E.
 Watson, Samuel D.
 White, Robert B.
 Williams, Dwight M.
 Williams, Jacob M.
 Ziomek, Stanley

Hempstead County

Downs, Michael
 Finley, George
 Harris, Lowell O.
 Holt, Forney G.
 McKenzie, Jim
 Perez, Eduardo M.
 Stevens, David G.
 Williams, Carl L.

Hot Spring County

Berry, Frederick B.
 Bollen, A. Ray
 Brashears, Larry B.
 Burton, Bruce K.
 Cobb, Russell W.
 Ellis, C. Randolph
 Highsmith, Vivian F.
 Kersh, N. B.
 Lumb, John C.
 Purifoy, Shawn
 Tilley, Absalom
 Vaughan, John A.
 White, Bruce A.
 White, Robert H.
 Willingham, Cynthia

Howard-Pike County

Chuadry, Zafar A.

Dunn, Robert
 Floyd, Mark A.
 Gullett, A. Dale
 Humphreys, T. J. Jr.
 King, Joe D.
 Martinazzo-Dunn, Anna
 Patel, Madanmohan
 Peebles, Samuel W.
 Sayre, John
 Sykes, Robert
 Turbeville, James O.
 Verser, Michael
 Ward, Hiram T.
 White, Phillip L.

Independence County

Alexander, William Steve
 Allen, James D.
 Angel, Jeff D.
 Baker, J.R.
 Baker, Robert V.
 Barnes, Seth Michael
 Bates, Ronald J.
 Beck, Dennis
 Beck, James F.
 Bess, Lloyd G.
 Brown, Hunter Lee
 Brown, Verona T.
 Cummins, Thomas
 Davidson, Andy
 Davidson, Dennis O.
 Goodin, William H. Jr.
 Hays, Sarah F.
 Jeffrey, Jay R.
 Johnson, Deborah A.
 Jones, Edward J.
 Jones, Edward T.
 Joseph, Aubrey S.
 Ketz, Wesley J.
 Lambert, John S.
 Lowery, Ronald
 Lytle, Jim E.
 McClain, Charles M. Jr.
 Melton, Clinton G.
 Montgomery, F. Renée
 Moody, Lackey G.
 Moody, Melody
 Neaville, Gregory
 O'Brien, Marcus D.
 Piediscalzi, Nicholas
 Posey, David L.
 Scott, John G.
 Shields, Mary Catherine
 Simpson, Ronald
 Slaughter, Bob L.
 Smith, Charles
 Sutterfield, Terry F.
 Taylor, Chaney W.

Taylor, Charles A.
 Thrasher, James R.
 Van Grouw, Richard
 Waldrip, William J. III
 Walton, Robert B.
 Webster, Russell P.
 Williams, Robin C.

Jackson County

Ashley, John D. Jr.
 Chauhan, Mufiz A.
 Dudley, Guilford M. III
 Falwell, K. Wade
 Frankum, Jerry M. Jr.
 Green, Roger L.
 Hergenroeder, Paul J.
 Hunt, Randall Evan
 Jackson, Jabez Fenton Jr.
 Jones, Karen Dee
 Junkin, A. Bruce
 Poon, Hon K.
 Reynolds, Roland C.
 Snodgrass, Phillip A.

Jefferson County

Alexander, Lester T.
 Ancalmo, Nelson
 Anderson, Charles W.
 Armstrong, Simmie Jr.
 Atiq, Omar T.
 Atkinson, Robbie
 Atnip, Gwyn
 Attwood, H. M.
 Bell, Carl H. Jr.
 Bigongiari, Lawrence R.
 Bitzer, Lon
 Blackwell, Banks #
 Bracy, Calvin M.
 Brooks, R. Teryl Jr.
 Broughton, Stephen A.
 Buckley, J. Wayne
 Buckner, Amy
 Busby, John
 Campbell, James C. Jr.
 Carlton, Irvin L.
 Cash, J. Steven
 Clark, Charles A.
 Crenshaw, John
 Davis, Charles M.
 Davis, Kurt G.
 Davis, Paul W.
 Dedman, John D.
 Deneke, William
 Dharamsey, Shabbir A.
 Duckworth, Thomas S.
 Dunaway, Joseph D.
 Fendley, Ann E.
 Fendley, Herbert F.

Flowers, Martha A.
 Forestiere, Lee A.
 Freeman, Tijuana L.
 Frigon, Jacquelyn S.
 Gardner, Dan R.
 Garner, Kimberly
 Green, Horace L.
 Gullett, Robert R. Jr.
 Harvey, Jerry L.
 Holaday, Lisa M.
 Hughes, L. Milton
 Hussain, Shafqat
 Hutchison, E. L.
 Hyman, Carl E.
 Irwin, Raymond A. Jr.
 Jacks, David C.
 Jacks, Dennis
 James, William J.
 Jenkins, Bobby
 Jenkins, Mary Ellen
 Johnson, Horace
 Jones, James III
 Jurkovich, David F.
 Justiss, Richard D.
 Langston, Lloyd G.
 Ligon, Ralph E.
 Lim, William N.
 Lindsey, James A.
 Lum, Don
 Lupo, David A.
 Lytle, John O.
 Mabry, Charles D.
 Malik, Shamim A.
 Marcus, Herschel
 Masood, Syed Kamil
 McDonald, Robert L.
 Meredith, William R.
 Miller, Donald L.
 Miller, Joseph Emile
 Milligan, Monte C.
 Mohiuddin, Mohammed J.
 Morris, Gerald C.
 Newan, Michael
 Nixon, David T.
 Nixon, William R.
 Nuckolls, J. William
 Pearce, Malcolm B.
 Pierce, J. R. Jr.
 Pierce, Reid
 Pierce, Ruston Y.
 Pollard, J. Alan
 Quimosing, Estelita M.
 Redman, Anna T.
 Reid, Lloyene B.
 Roaf, Sterling A.
 Roberson, George V. Jr.
 Robinson, Paul F.
 Rogers, Henry L.

Ross, Robert L.
 Samuel, Ferdinand K.
 Shorts, Stephen D.
 Shrum, Kelly
 Simmons, Calvin R.
 Simpson, P. B. Jr.
 Smith, Paul L.
 Stark, James
 Stern, Howard S.
 Sullenberger, A. G.
 Tejada, Ruben
 Townsend, Thomas E.
 Tracy, C. Clyde
 Trice, James
 Ulep, Benjamin T.
 Walajahi, Fawad H.
 Washington, Erma
 Wilkins, Walter J. Jr. #
 Wineland, Herbert L.
 Worrell, Aubrey M. Jr.
 Wright, Steven H.

Johnson County

Goodman, James David
 Kuykendall, Scott
 McKelvey, Richard
 Pennington, Donald H.
 Shrigley, Guy P. #

Lafayette County

Harbin, Bradley
 Lee, Willie J.

Lawrence County

Davidson, Charles D.
 Hughes, Joe E.
 Joseph, Ralph F.
 Lancaster, Shawn
 Lancaster, Ted S.
 Quevillon, Robert D.
 Spades, Sebastian A. III

Lee County

Balke, Susan W.
 Gray, Dwight W.
 Ly, Duong N.
 Waddy, Leon Jr.

Little River County

Covert, George K.
 Kile, H. Lawson Jr.
 Kleinschmidt, Kevin C.
 Peacock, Norman W. Jr. #
 Vorhease, James W.

Logan County

Ahmed, Sahibzada
 Alexander, Eugene

Borklund, Maurice K.
Buckley, Douglas A.
Daniel, William R.
Enns, Wayne P.
Harbison, James D.
Richey, Jason D.

Lonoke County

Abrams, Joe A.
Anderson, Leslie
Braswell, Thomas
Holmes, Byron E.
Inman, Fred C. Jr.
Merritt, James M.
Paslidis, Nick J.
Rochelle, Joe
Schumann, Gerald M.
Shurley, Floyd Jr.
Wilcox, Linda G.

Miller County

Alkire, Carey
Andrews, A. E. Jr.
Barnes, Walter C. Jr.
Blankenship, D. Michael
Burns, Billy R.
Campanini, D. Scott
Carlisle, David L.
DeHaan, Jeffrey T.
Dildy, Edwin V. Jr.
Ditsch, Craig E.
Dodd, N. Leland
Dodge, John M.
Duncan, Donald L.
Ford, John Suffern
Franks, Hayden
Gabbie, Mark
Graham, John
Green, R. Clark
Griffin, Nancy
Hillis, Thomas M.
Hollingsworth, Charles E. II
Hughes, A. Keith
Jean, Alan B.
Jones, John W.
Joyce, F. E.
Kittrell, James
Knowles, Stanley C.
Loe, Arlis W.
McGinnis, Robert S. Sr.
Morris, Howard
Norris, John A.
O'Banion, Dennis
Peebles, Larry M.
Robbins, Joseph
Robertson, William J.
Rountree, Glen A.
Royal, Jack L.

Sarrett, James
Schmidt, Howard
Shipp, G. Carl
Smith, Arnett D. Jr.
Smith, Christopher T.
Smolarz, Gregory J.
Solomon, J. Alan
Somerville, Patrick J.
Spence, Shanna
Stringfellow, Jerry B.
Stussy, Shawn
Thomas, Jeffery
Tompkins, William Jr.
Tyler, Richard L.
Vereen, Lowell E.
Wade, Billy
Wilhelm, Frieda
Wren, Herbert B.
Wright, Nathan L.
Yarbrough, Charles P.
Young, Mitchell

Mississippi County

Abraham, Anes Wiley
Abramson, Lawrence
Anderson, Laurie Jean
Bell, Mary C.
Biggerstaff, Jerry
Brock, Charles C. Jr.
Butler, Judith Arlene
Cullom, Sumner R.
Fairley, Eldon
Fergus, R. Scott
Hester, Karen Calaway
Hester, Richard
Hubener, Louis F.
Hudson, James H.
Husted, G. Scott
Jones, Herbert
Jones, Joe V.
Lin, Ching-Shan
LoCascio, Paul A.
Marcus, Trent Wright
Osborne, Merrill J.
Pollock, George D.
Rhodes, Joseph
Rodman, T. N.
Russell, James D.
Shahriari, Sia
Shaneyfelt, E. A.
Smith, Ronald D.
White, John Stephen
Williams, John S.

Monroe County

Campos, Amador
Collins, Linda
David, Neylon C. Jr.

Pham, Dac Tat
Pupsta, Benedict F.
Stone, Herd E. Jr.
Walker, Walter L.

Ouachita County

Abbott, Judy
Blagdon, Donald G.
Braden, Lawrence F.
Brunson, Milton
Crump, Mark R.
Daniel, William A.
Dedman, William D.
Floss, Robert
Fohn, Charles H.
Guthrie, James
Hartman, Raymond P.
Hout, Judson N.
Jameson, John B. Jr.
Kelly, Patricia
Kendall, Jerry R.
Martin, Dan
McFarland, Gale
Mosley, David
Nunnally, Robert H.
Ozment, L. V.
Sanders, Cal R.
Shrestha, Bal Narayan
Thorne, Arthur E.

Phillips County

Athota, Prasad J.
Barrow, John H. Jr.
Bell, L. J. Patrick
Bell, L. J. Patrick II
Berger, Alfred A.
Epstein, S. Mitchell
Faulkner, Henry N.
Frederick, William Ronald
Hall, Scott
McCarty, Charles P. #
McCarty, Gordon E. Jr.
McDaniel, Marion A.
Miller, Robert D. Jr.
Paine, William T.
Patton, Francis M.
Rangaswami, Bharathi
Rangaswami, Narayanaswami
Tukivakala, P. Reddy
Vasudevan, Kanaka
Vasudevan, P.
Webber, David L.
Winston, William II
Wise, James E. Jr.

Polk County

Beckel, Ron Jr.
Cappello, Nicholas A.

Coutts, William II
Finck, John Henry
Fried, David D.
Lochala, Richard
Mesko, John D.
Perry, Karen A.
Sosa, Humberto J.
Tinnesz, Thomas
Wilson, Timothy #
Wood, John P.

Pope County

Allison, Russell
Ashcraft, Ted
Austin, Nathan
Bachman, David S.
Barron, William G.
Barton, A. Dale
Battles, Larry D.
Beavers, H. Kevin
Bell, Michael
Bell, Robert A.
Berner, Dennis W.
Birum, Patricia J.
Bradley, Stanley C.
Brown, Charles H.
Brown, William Bruce
Burgess, James G.
Callaway, Jody C.
Carter, James M.
Cloud, Joe A.
Crouch, James Jr.
Crumpler, Joe B. Jr.
Cunningham, James A.
Duffield, Robin P.
Dunn, Donald L.
Ewing, Donald C.
Ezell, Gerry D.
Ferris, Craig A.
Galloway, William W.
Gately, Stanley
Haines, Lynn
Hale, Jeffrey
Harden, V. Anthony
Harrison, Rick
Helms, William
Henderson, Vickie L.
Hendren, Mike
Hill, Donald F.
Hines, Cynthia C.
Honghiran, Ted
Hubach, Cindy
Kerin, Douglas
Khan, Gul Rukh
Khan, Muhammad A.
Killingsworth, Stephen M.
King, John W.
King, W. Ernest Jr.

Kolb, James M. Jr.
 Kriesel, Ben J.
 Lawrence, Frank M.
 Lee, John R.
 Lovell, Richard K. Sr.
 Lowrey, Douglas H.
 Lowther, Laura Marie
 Massey, V. Rudolph
 Mauch, E. Jane
 May, Robert H. Jr.
 McCraw, Barry W.
 Meyer, Kelly H.
 Monfee, Andrew M.
 Murphy, David S.
 Myers, Gary Dean
 Myers, J. Mark
 New, Kenneth O.
 Pilkington, Neylon S.
 Price, Kevin S.
 Price, Larry
 Richison, George C.
 Riddell, C. Michael
 Riley, Don C.
 Soto, Sergio F.
 Stolz, Gerald A. Jr.
 Tapley, Thomas S.
 Teeter, Stanley D.
 Thurlby, W. Robert
 Turner, Finley P. II
 Turner, Kenneth B.
 West, Boyce W.
 White, Ronald
 Wilkins, Charles F. Jr.
 Williams, David M.
 Williams, Thomas C.
 Young, Charles

Pulaski County

Abel, Lee C.
 Abraham, Dana C.
 Abraham, James H. III
 Abraham, James H.
 Ackerman, William E. III
 Adametz, James
 Adametz, John Sr.
 Adametz, Kimberly
 Adams, Christopher
 Adamson, James
 Alexander, Albert S.
 Alford, T. Dale
 Allen, Durward Jr.
 Allen, John E. Jr.
 Alston, Phillip
 Aquino, Al
 Araoz, Carlos
 Archer, Robert L.
 Arrington, Robert
 Atha, Timothy C.

Atkinson, Evangelina
 Baber, John C.
 Baber, John T.
 Backus, Joe T.
 Bailey, H. A. Ted Jr.
 Baker, Glen F.
 Baker, John W.
 Baker, Johnson
 Baldwin, Maxwell R.
 Baldwin, Shelly
 Baltz, Brad Patrick
 Barber, Jeffrey
 Barber, Laurie
 Barclay, David
 Bard, David S.
 Barger, Denver L.
 Barlow, Brian E.
 Barnes, C. Lowry
 Barnes, Reginald
 Barnes, Robert W.
 Barnett, David
 Barnett, Troy F. #
 Barone, Gary
 Barron, Edwin N. Jr.
 Barrow, Robert
 Bartnicke, Benjamin J.
 Barton, Gary
 Baskin, Barry
 Bates, Joseph H.
 Bates, Ramona L.
 Bates, Stephen
 Bauer, David
 Bauer, F. Michael
 Bauer, Frank M. Jr.
 Bauman, David C.
 Bayliss, John M.
 Beadle, Beverly
 Bearden, James R.
 Beaton, J. Neal
 Beau, Scott
 Beck, Joseph II
 Becquet, Norbert J.
 Belknap, Melvin L.
 Bell, Rex H.
 Bennett, F. Anthony Jr.
 Benton, William
 Berry, Robert L.
 Bevans, David W. Jr.
 Bienvenu, Gregory
 Bienvenu, Harold G. III
 Bierle, Michael
 Billie, James
 Biondo, Raymond V.
 Birkett, Ian McRae
 Bishop, William B.
 Blackshear, Jack L. Jr.
 Blankenship, William F.
 Blasier, R. Dale

Boehm, Timothy
 Boellner, Samuel W.
 Boger, James E.
 Boop, Bradley Scott
 Boop, Frederick
 Boop, Warren C. Jr.
 Bost, Roger B.
 Bourne, David E.
 Bowen, W. Scott
 Bower, Charles M.
 Boyd, Charles M.
 Bradburn, Curry B. Jr.
 Bradford, J. David
 Bradley, Joe F.
 Brainard, Jay O.
 Bressinck, Renie E.
 Brewer, Robert
 Brimberry, Ronald K.
 Brineman, John
 Brinkley, Roy A.
 Brizzolara, A. J.
 Brizzolara, John Paul
 Broach, R. Fred
 Broadwater, John Ralph Jr.
 Brown, Michael
 Brown, Pamela S.
 Brown, Randel
 Brown, Steven L.
 Browning, Donald G.
 Browning, Stanley K.
 Bruce, Thomas A.
 Bryan, James W. IV
 Buchanan, Francis R.
 Buchanan, Gilbert A.
 Buchman, Joseph K.
 Bucolo, Anthony P.
 Buford, Joe L.
 Burba, Alonzo R.
 Burger, Robert A.
 Burks, Karen
 Burnett, Hugh F.
 Burrow, Dennis R.
 Byrum, Jerry
 Calcote, Robert A.
 Calderon, Vincent Jr.
 Caldwell, Charles R.
 Calhoon, J. Dale
 Calhoun, Joseph D.
 Calhoun, Richard A.
 Campbell, Gilbert S.
 Campbell, James W.
 Caplinger, Kelsy J. III
 Carfagno, Jeffrey
 Carle, Scott W.
 Carson, Layne E.
 Carter, Jerry L.
 Carttar, Charles
 Caruthers, Carol

Caruthers, Samuel B. Jr.
 Casali, Robert E.
 Cash, Darlene
 Casper, Robert B.
 Casteel, Helen
 Cate, Chris M.
 Cathey, Janet
 Cathey, Steven
 Chai, Sandra
 Chakales, Harold H.
 Chandler, Billy M.
 Chandler, Kay H.
 Chappell, Carol W.
 Cheairs, David B.
 Cheairs, John T.
 Chisholm, Dan P.
 Choate, Robert B.
 Christian, John D.
 Christy, George W.
 Chudy, Amail
 Church, Marion M.
 Church, Michael
 Clark, Richard B.
 Clift, Steven A.
 Clifton, Cliff
 Clinton, Kimberly S.
 Clogston, Charles W.
 Cobb, Jock S.
 Cockrill, H. Howard Jr.
 Cogburn, Bob E.
 Colclasure, Joe B.
 Collins, David
 Collins, Gary James
 Collins, Kevin J.
 Colwell, Karen Louise
 Cone, John
 Cook, J. Mitchell
 Cook, Timothy R.
 Cooper, Keith W.
 Cope, Michael
 Corbitt, Mary
 Cornell, Paul J.
 Courtney, Willis Jr.
 Coussens, David M.
 Covey, M. Carl Jr.
 Crawford, Cary M.
 Crews, J. Travis
 Crocker, Charles H.
 Cross, J. B.
 Crow, Joe W.
 Crow, R. Lewis Jr.
 Darwin, William G.
 Daugherty, Joe D.
 Daugherty, John L.
 David, Alex
 Davie, Melanie
 Davila, David G.
 Davis, Glenn R.

Davis, J. Lynn	Frazier, Cynthia	Harris, Nita	Hutchins, Steven W.
Davis, Scott A.	Frazier, G. Thomas	Harris, T. Stuart	Hutson, Harold G.
Day, James A.	Freeman, Diane	Harris, W. Turner	Ingram, Jim
De Bruyn, Van H.	Fuller, C. Dale	Harrison, A. Vale	Ironside, J. Brett
Dean, David M.	Fuller, C. James III	Harrison, Roy E.	Jackson, J. Presley
Dean, David P.	Fulmer, John M.	Harrison, William	Jackson, Richard J.
Dean, Gilbert O.	Galbraith, Robert C.	Harshfield, David Lee Jr.	Jackson, Thomas #
Deaton, C. William Jr.	Gardner, Guy F.	Hart, Thomas M.	Jansen, G. Thomas
Deed, Ashley	Garner, William L.	Harter, Scott	Johns, Richard D.
Deer, Philip J. Jr.	Gettys, Joseph M. Jr.	Hatch, Allan B.	Johnson, Anthony D.
Deer, Philip James III	Gibbs, Mark	Hathcock, Stephen A.	Johnson, B. Richard
Dennis, James L.	Gibson, Gordon L.	Hauer-Jensen, Martin	Johnson, Ben D.
DesLauriers, S. Killeen	Giglia, Anthony R. III	Hayden, William F.	Johnson, Carl
Dickins, John R. E.	Giles, Wilbur M.	Hayes, J. Harry Jr.	Johnson, Clifton R.
Dickins, Robert D. Jr.	Gillespie, A. Tharp	Hayes, Richard L.	Johnson, Dianne Flowers
Dillard, Daniel C.	Gilliam, David	Hayes, Sidney P.	Johnson, M. Bruce
Diner, Bradley	Gist, Charles C.	Haynes, W. Ducote	Johnson, Philip H.
Dixon, Keith A.	Glenn, Wayne B.	Headstream, James W.	Johnston, Dale E.
Dodd, Doyne	Glover, Lawson E. Jr.	Heard, Adele	Johnston, Kenneth
Doncer, Richard P.	Glover, W. Clyde	Hearnsberger, H. Graves III	Jones, Gail Reede
Doucet, Marlon J.	Golden, William E.	Hearnsberger, Henry G. Jr.	Jones, Garry L.
Douglas, Warren M.	Goldsmith, Geoffrey	Hearnsberger, John E.	Jones, John C.
Downs, Ralph A.	Gosser, Bob L.	Hedges, Harold H.	Jones, Kathleen C.
Driskill, Angela	Goza, Gary R.	Hefley, Bill F. Sr.	Jones, Robert D.
Dungan, William T.	Goza, George M. Jr.	Hefley, William Jr.	Jones, Roy Steven
Dunnagan, Steven A.	Grant, Karen G.	Henker, Fred O. III	Jones, S. Michael
Dwyer, Gregory A.	Green, Benny J.	Henry, C. Reid Jr.	Jones, William N.
Eans, Thomas L.	Greenway, C. Don	Henry, D. Andrew	Jordan, F. Richard
Easter, Rex M.	Greenwood, Denise R.	Henry, G. Michael	Jordan, Randy A.
Edmiston, Frank G.	Greer, G. Stephen	Henry, G. Morrison	Joseph, Ralph F. II
Eisenach, R. Jeffrey	Greutter, John E. Jr.	Henry, J. Charles	Joseph, William Frank
English, Jim	Griebel, Jack A. Jr.	Henry, J. Forrest Jr.	Jouett, W. Ray
Evans, Billy	Grimes, H. Austin	Henry, Richard Y.	Joyce, John W.
Evans, Samuel C.	Guard, Peggy K.	Henry, W. Bradley	Junkin, Ruth H.
Farmer, Joseph F.	Guggenheim, Frederick G.	Henry, William T.	Kaemmerling, Raymond E.
Farque, Greg L.	Guin, Jere D.	Henson, Gregory N.	Kahn, Alfred Jr.
Fernandez, Agustin	Hagans, James III	Herron, Jerry M.	Kane, James J.
Ferris, Ernest J.	Hagler, James L.	Hickey, Joseph P.	Keeran, Michael G.
Fewell, Ronald D.	Hahn, Herbert	Hicks, David C.	Keith, Sharon C.
Fielder, Charles R.	Hall, A. D.	Hicks, David L.	Kellar, Stanley L.
Finan, Barre F.	Hall, A. David	Hixson, Marcia Lynn	Keller, Alfred W.
Fincher, Robert L.	Hall, Gregory S.	Hodges, J. Timothy	Kennedy, Eleanor E.
Fiser, Martin	Hall, R. Whit	Hodges, Steven C.	Kennedy, H. Frazier
Fiser, Robert H. Jr.	Hamilton, George Jr.	Hoffmann, Thomas H.	Kennedy, Robert
Fiser, William P. Jr.	Hampton, John R. III	Holland, Jay D.	Ketcham, Jeffrey
Fitzgerald, Charles	Hankins, Edwin III	Holloway, J. Douglas	Key, J. Michael
Fitzhugh, A. Stuart	Hanna, Ehab	Holt, Stephen	Kilgore, Reed W.
Flaming, Jay	Harber, Harley	Holton, Jerry C.	King, Michael T.
Fletcher, Anthony	Hardberger, R. E.	Hopkins, Karmen	King, W. David
Fletcher, Thomas M.	Hardin, Robert	Hough, Aubrey J. Jr.	Kittler, Fred J.
Florez, James P.	Hardin, Ronald D.	Houk, Richard	Kizziar, Jim C.
Floyd, Bill G.	Harger, C. Harold	Houston, Samuel	Klimberg, V. Suzanne
Ford, Barry G.	Hargrove, Joe L.	Howell, Coburn S. Jr.	Knott, Patricia A.
Foster, Gil	Harper, Gary E.	Hudec, Regina	Knox, Michael F.
Fraiser, Lacy P.	Harrendorf, Cagle	Hughes, Ronald D.	Kolb, Agnes J.
France, Gene L.	Harrington, G. Scott	Hundley, Randal F.	Koonce, Thomas W.
Fraser, Eric A.	Harrington, Mariann	Hurlbut, Kimberly	Kovaleski, Thomas M.
Fravel, Jonathan F.	Harris, Donald R.	Hutchins, Laura	Kozlowski, Karen J.

- Krulin, Gregory S.
 Kuhn, Ronald
 Kulik, Steven A.
 Kumpuris, Andrew G.
 Kumpuris, Dean
 Kumpuris, Frank G.
 Kusenberger, Don Levi
 Kyle, Joan E.
 Kyser, J. Floyd
 Laakman, Robert W.
 Lambert, Robert A.
 Landers, James H.
 Lane, John W.
 Lang, Nicholas P.
 Langford, Timothy
 Lehmberg, Robert W.
 Leibovich, Marvin
 Leithiser, Richard Jr.
 Leonard, Donald G.
 Leou, Frank J.
 Lewis, Derek
 Lile, Henry A.
 Lincoln, Ben M.
 Lipke, Jay M.
 Loeb, Edward C.
 Logan, Charles W.
 Love, Tommy L. Jr.
 Lowe, Betty A.
 Lu, Eugene
 Ludwig, Frank R.
 Luttrell, Rex E.
 Lyons, Virgle E. Jr.
 Mabrey, William
 Magie, Stephen K.
 Magnes, Scott A.
 Mallory, John A.
 Maloney, F. Patrick
 Maners, Ann
 Markland, Gary S.
 Marks, Stephen R.
 Marotti, A. Scott
 Martin, Kenneth A.
 Marvin, Peter
 Mason, J. Zachary
 Mason, William L.
 Massey, Deborah A.
 Matthews, Joseph W.
 McCarthy, Richard E.
 McCasland, Leslie D.
 McConnell, John D.
 McCoy, Julia M.
 McCracken, Gail Ann
 McCracken, John
 McCrary, George A.
 McDonald, James E.
 McDonald, Judy
 McGhee, Judith E.
 McGhee, Michael A.
 McGowan, Robert Jr.
 McGrew, Robert N.
 McKelvey, K. David
 McKnight, C. Allen
 McLaughlin, Shannon
 McLeane, Mark
 McNair, James R.
 McNee, Valerie
 Meacham, Donald F.
 Meador, Annette Parker
 Meadors, Carol
 Meadors, Frederick
 Meadors, John
 Medlock, Rickey D.
 Mego, David Michael
 Mellor, Roy II
 Mendelsohn, Lawrence A.
 Mettrailer, James A.
 Meziere, Tom
 Miles, David A.
 Miller, Forrest B. Jr.
 Miller, Raymond P. Sr.
 Milner, E. L.
 Mitchell, George K.
 Mizell, Philip
 Mizell, Walter S.
 Moffett, T. Robert Jr.
 Money, Wandal D.
 Montanez, Josue
 Mooney, Donald K.
 Moore, Burton A.
 Moore, J. Malcolm Jr.
 Moore, Michael
 Moore, Rex N.
 Moore, Robert B.
 Moore, Thomas C.
 Morris, Barbara
 Morris, W. Dale
 Morrison, Debra F.
 Morse, James C.
 Morton, William J.
 Mulhollan, James S.
 Murphy, Bruce
 Murphy, James E. Jr.
 Murphy, Jeanne
 Murphy, Randolph
 Murphy, Robert
 Murphy, Tena
 Nagel, Fred G.
 Nair, Balan A.
 Napolitano, Charles A.
 Nash, John C.
 Nelson, Alvah J. III
 Nelson, Carl L.
 Nestrud, Richard M.
 Newbern, D. Gordon
 Newsum, Jon Kirby
 Newton, Fred E.
 Nguyen, Duong
 Nichols, Sandra D.
 Nix, Richard A.
 Nokes, Steven
 Norton, George A.
 Norton, Joseph A.
 Nowlin, James Bill
 Nugent, Richard
 Oates, Gordon P. #
 Oddson, Terrence A.
 Oglesby, Walter R.
 Osam, Patrick N.
 Osteen, Paul
 Overacre, Robert
 Owen, Richard Jr.
 Owings, Richard
 Padberg, Frank T.
 Paddock, George
 Padilla, Fernando
 Pappas, James J.
 Parham, David M.
 Parker, J. Mayne
 Parkhurst, James
 Parmley, Tim
 Parnell, Clifton L. III
 Pastor, Randy
 Patrick, Larry L.
 Paulus, Thomas E.
 Pearce, Charles E.
 Peek, Richard
 Peebles, R. Earl
 Peters, John E.
 Peters, Phillip J.
 Petrus, Gary M.
 Petursson, Gissur J.
 Pevahouse, Joe
 Phillips, Charles E.
 Phillips, Hannah
 Pierce, William
 Pike, John D.
 Pledger, Norman R.
 Pollard, Arlee E.
 Pollock, Michael Marion
 Pope, Christopher H.
 Pope, Norton A.
 Porter, Robert Jr.
 Potts, Jerry L.
 Power, Robert C.
 Prather, Jerry L.
 Price, John G.
 Pringos, Andrew A.
 Pruitt, Tad
 Pyle, Hoyte R. Jr.
 Quinn, Brian D.
 Ransom, John M.
 Rapp, Richard J.
 Raque, Carl J.
 Ray, V. Gail
 Rector, Nancy F.
 Redding, Allen H.
 Reding, David L.
 Redman, John F.
 Reed, Ewing C. Jr.
 Reese, William G.
 Reid, Gene W.
 Rimmel, Raymond
 Rice, James Curtis
 Rice, Robert L.
 Riddle, John F. Jr.
 Riley, William H.
 Ritchie, Robert Ross
 Robbins, Kenneth
 Roberson, Michael C.
 Roberts, Kevin
 Rodgers, C. Dudley
 Rodgers, Charles H.
 Rooney, Thomas P.
 Rosenbaum, Carl A.
 Ross, Ashley Sloan
 Ross, Cynthia
 Ross, S. William
 Rounsaville, Harry L.
 Ruddell, Deanna N.
 Ruggles, Dwayne L.
 Russell, Anthony E.
 Ryals, Rickey O.
 Saer, Edward H. III
 Safman, Bruce L.
 Sanders, Kelli Keene
 Santoro, Ian H.
 Satre, Richard W.
 Sauer, Curtis
 Schlesinger, Scott Michael
 Schock, Charles C.
 Schratz, Bruce E.
 Schroeder, George T.
 Schultz, John C.
 Schwander, L. Howard
 Schwankhaus, John D.
 Scott, Jane F.
 Scruggs, Jan W.
 Searcy, Robert M.
 Seguin-Calderon, Rosa Elia
 Seibert, Joanna J.
 Seibert, Robert
 Selakovich, Walter G.
 Sessions, Louis II
 Shewmake, Kristopher B.
 Shields, Eddie
 Shock, John P.
 Short, Harold K.
 Shotts, Joseph
 Shuffield, James
 Silvano, Gerald R.
 Silzer, Robert R.
 Simmons, Debra Lynn

Simmons, Orman W.
 Simpson, Steve
 Sims, James M.
 Singer, Peter
 Singleton, L. Gene
 Sipes, Frank M.
 Sitarik, Kathleen
 Skokos, C. Kemp
 Slater, John G. Jr.
 Slaven, John E.
 Slayden, John E.
 Sloan, Eugene E.
 Sloan, Fay M.
 Smart, Douglas F.
 Smelz, Johnny
 Smith, Aubrey C.
 Smith, Charles W.
 Smith, David E.
 Smith, Douglas B.
 Smith, G. Richard Jr.
 Smith, J. Tom
 Smith, James L.
 Smith, Purcell Jr.
 Smith, Thomas J.
 Smith, Thomas W.
 Smith, Vestal B. Jr.
 Snyder, Victor F.
 Somers, A. Jack
 Sorrells, R. Barry
 Sotomora, Ricardo F.
 Squire, Arthur E. Jr.
 St Amour, Thomas E.
 Stallings, James Walt
 Stanley, Joe P.
 Stanley, Robert
 Stephens, Wanda
 Stern, Scott J.
 Sternberg, Jack J.
 Stewart, Bobby Ray
 Stewart, Daryl
 Stewart, Marguerite R.
 Stewart, Tracy D.
 Stinnett, Thomas
 Stokes, B. Douglas
 Storeygard, Alan R.
 Stotts, John R.
 Stout, Kimber
 Strauss, Mark A.
 Stringer, Warren
 Strode, Steven W.
 Stroope, George F.
 Studdard, James D.
 Sturdivant, Stephen
 Suen, James
 Sulieman, J. Samir
 Sullivan, Charles D.
 Sullivan, Jan R.
 Sundermann, Richard H.

Suphan, Neema A.
 Talbert, Gary Eugene
 Talbert, Michael L.
 Tamas, David E.
 Tanner, James A.
 Taylor, David R.
 Taylor, Eugene H.
 Taylor, Ken M.
 Taylor, Martin A.
 Tedford, John G.
 Tharp, John G.
 Thomas, A. Henry
 Thomas, Peter O.
 Thomason, Steven L.
 Thompson, S. Berry Jr.
 Thorn, G. Max
 Tilley, Steve
 Tolleson, Claudia
 Towbin, Eugene J.
 Tracy, Phillip A.
 Trantum, Bill L.
 Trigg, Laura
 Tseng, Jyi-Ming
 Tucker, R. Stephen
 Tucker, W. Everett
 Valentine, Robert G. Jr.
 Van Zandt, Janelle
 Vaughter, W. Roger #
 Velez, Duane
 Vinsant, Kurtis
 Vogel, Robert G.
 Wade, William I. Jr.
 Wagoner, Jack
 Walker, Lee
 Walker, Ronald
 Walt, James R.
 Waner, Milton
 Ward, Harry P.
 Ward, Joseph P.
 Ward, Thomas
 Watkins, Charles J.
 Watkins, John Jr.
 Watkins, John G. III
 Watkins, Julia
 Watkins, Larry S.
 Watson, Charles
 Watson, Daniel W.
 Watson, Vye B.
 Weber, Edward R.
 Weber, Michael
 Weiss, David W.
 Weiss, Gerald N.
 Welch, Samuel Bradley
 Wellons, James A. Jr.
 Wende, Raymond A.
 Wenger, Carl E.
 West, Joseph
 Westbrook, Kent C.

Westbrook, September
 Westerfield, Frank M. Jr.
 Westerfield, Robert
 Wilkes, Elbert H.
 Wilkes, T. David I.
 Williams, Alonzo D.
 Williams, C. David
 Williams, G. Doyne Jr.
 Williams, Paul E.
 Williams, Ronald N.
 Williamson, Adrian III
 Wills, Pamela
 Wilson, Elaine
 Wilson, Frances C.
 Wilson, Frank J. Jr.
 Wilson, I. Dodd
 Wilson, James W.
 Wilson, John L.
 Wolverton, John
 Workman, W. Wayne
 Worley, Linda
 Wortham, Thomas H.
 Wyatt, Richard A.
 Wylie, Paul
 Yamauchi, Terry
 Yeager-Bock, Angy
 Yee, Suzanne
 Yocum, John
 Young, Douglas E.
 Young, Evelyn
 Zelnick, Paul
 Ziller, Stephen A. III

Randolph County

Baltz, Albert L.
 Barre, Hal S.
 DeClerk, Thomas
 Guntharp, George
 Holt, Danny B.
 Jansen, Andrew J. III
 Smith, Norman K.
 Troxel, Roger

Saline County

Albey, Mark
 Baber, Quin M.
 Baka, John V.
 Beard, Michael R.
 Bethel, James
 Boyle, Ronald H.
 Brashears, Clay
 Burton, Charles R.
 Caldwell, David L.
 Cartaya, Daniel I.
 Cash, Ralph D.
 Cathcart, Evelyn
 Chaffin, Raines
 Coker, S. Dale

Cooper, James B.
 Council, Robert A. Jr.
 Dixon, Jerry W.
 Dockery, Melissa
 Duncan, J. Shelby
 Eaton, James M.
 Enderlin, Annette
 Harper, Donald
 Higginbotham, Michael
 Hill, Edward B.
 Hill, Howell V.
 Hogue, F. Paul
 Kirk, Marvin N. Jr.
 Martindale, J. L.
 Martindale, Mark A.
 McGarry, Patricia G.
 Quade, Deborah
 Ramsay, Rex C. Jr.
 Schally, Gordon R.
 Schmidt, Michael J.
 Steele, William L.
 Sudderth, Brian F.
 Taggart, Sam D.
 Thibault, Frank G. Jr.
 Thomas, Bill R.
 Thorn, Harvey Bell Jr.
 Tilley, Roger L.
 Ulmer, Stacy L.
 Vice, Mark
 Viner, Donald L.
 Wagner, Taylor
 Watson, Kirk D.
 Wilson, R. Sloan
 Wright, John D.

Sebastian County

Acklin, Jimmy D.
 Aclin, Richard R.
 Al-Ghussain, Emad A.M.M.
 Albers, David G.
 Alberty, Joe
 Anderson, Paul
 Armstrong, Sinclair Jr.
 Asbury, Dale W.
 Atkins, Jimmie G.
 Axelsen, Nils K.
 Bailey, Charles W.
 Baker, Max A.
 Balsara, Zubin
 Barnes, L. Ford
 Barr, Marilyn
 Barry, James Jr.
 Basinger, Norma Smith
 Beachy, Allen L.
 Beene-Lowder, Hannah L.
 Berryhill, Richard E.
 Berumen, Mike
 Bise, Roger N.

Bodiford, Gary L.
 Bordeaux, Ronald A.
 Bouton, Michael S.
 Bradford, A. C.
 Brown, Byron L.
 Brown, James A.
 Brown, Richard
 Buie, James H.
 Builteman, James
 Burks, Deland
 Busby, J. David
 Cain, Martin
 Callaway, Michael
 Carson, Randall L.
 Cassady, Calvin R.
 Chalfant, Charles
 Chapman, Robert K.
 Chester, Robert L.
 Cheyne, Thomas
 Christopher-Harmon, Pamela
 Coffman, Edwin L.
 Coffman, John L.
 Coleman, Michael D.
 Craft, Charles
 Crow, Neil E. Jr.
 Culp, William C.
 Davenport, O. Leo
 De La Rosa, Raymond E.
 Deaton, John M.
 Deneke, James S.
 Diment, David D.
 Dorzab, Joe H.
 Drolshagen, Leo F. III
 Dudding, William F.
 Eckes, Anne Michelle
 Edwards, Gary
 Ellis, Homer G.
 Ennen, Randy
 Farris, Paul E.
 Feder, Frederick P. Jr.
 Feezell, Randall E.
 Feild, T. A. III
 Felker, Gary V.
 Ferrell, Jeffrey
 Fisher, Robert D.
 Flanagan, A. Dean
 Fleck, Randolph Peter
 Fleck, Rebecca
 Flippin, Tony A.
 Floyd, Charles H.
 Francis, Darryl R. II
 Gardner, Kenneth
 Gast, Kristie L.
 Gedosh, Edgar A.
 Gill, James A.
 Gills, Edward Larry
 Girkin, R. Gene
 Glover, D. Bruce

Gold, Adam
 Goodman, R. Cole Jr.
 Goodman, Raymond C. Sr.
 Griggs, William L. III
 Gwartney, Michael P.
 Hanley, Larry L.
 Haraway, Stuart D.
 Harrison, Lonnie Eugene
 Hendrickson, Jon
 Henry, James
 Herren, Adrian L.
 Hewett, Archie L.
 Hoffman, John D.
 Hoge, Marlin B.
 Holmes, Williams C. Jr.
 Hornberger, Evans Z. Jr.
 Howell, James T.
 Howell, Paul K. Jr.
 Hughes, Robert P. Jr.
 Hunton, David W.
 Huskison, William T.
 Ibrahim, Manar S.A.
 Ihmeidan, Ismail H.
 Ingram, Ralph N.
 Irwin, Peter J.
 Jagers, Robert
 Janes, Robert H. Jr.
 Johnson, Arthur M.
 Jones, Greg T.
 Kannout, Fareed
 Kareus, John L.
 Kelly, James E. III
 Kelly, Thomas C.
 Kelsey, J. F.
 Keyashian, Mohsen
 Kientz, John Jr.
 Klopfenstein, Keith
 Knox, Robert
 Kocher, David B.
 Koenig, Albert S. Jr.
 Kradel, R. Paul
 Kramer, Ralph G.
 Kutait, Kemal E.
 Kyle, W. Lamar
 Lambiotte, Louis O.
 Landherr, Edwin
 Landrum, Samuel E.
 Lane, Charles S. Jr.
 Lenington, Jerry O.
 Lewis, George L.
 Lilly, Ken E.
 Lilly, Kenneth E. Jr.
 Little, Charles
 Lockwood, Frank M.
 Long, James W.
 Loyd, Gregory M.
 MacDade, Albert D.
 Magness, Jack L. Jr.

Manus, Stephen C.
 Marsh, Michael A.
 Martimbeau, Claude
 Martin, Art B.
 Martin, Maurice
 Masri, Hassan M.
 Maxey, H. Craig
 McCarty, Joseph
 McClain, Merle
 McClanahan, J. David
 McEwen, Stanley R.
 McMinimy, Donald
 Miller, Robert C.
 Miller, Robert M.
 Mings, Harold H.
 Moore, Trudy J.
 Moore-Farrell, Laura
 Mosley, Myra C.
 Moulton, Everett C. Jr.
 Mumme, Marvin E.
 Musick, Stanley C.
 Muylaert, Michel
 Nassri, Louay K.
 Nelson, Steve B.
 Nichols, David R.
 Nolewajka, Andre J.
 O'Bryan, Robert K.
 Olson, John D.
 Paris, Charles H.
 Parker, Joel E. Jr.
 Parker, Thomas G.
 Pearce, Larry W.
 Pence, Eldon D. Jr.
 Pham, Thuylinh H.
 Phillips, Don
 Phillips, Kevin Clark
 Phillips, Sumer
 Pillstrom, Lawrence G.
 Poe, McDonald Jr.
 Poole, M. Louis
 Post, James M.
 Prewitt, Taylor A.
 Price, Claire
 Price, Lawrence C.
 Rabideau, Dana P.
 Raby, Paul L.
 Raymond, Thomas H.
 Rivera, Ernesto
 Robinson, Ronald P.
 Romero, Alfred T.
 Russell, Debra
 Russell, Rex D.
 Sanders, Robert E.
 Sanders, Robert V. III.
 Saviers, Boyd M.
 Schemel, William H.
 Schkade, Paul A.
 Schwarz, Julio

Schwarz, Paul R.
 Seffense, Stephen J.
 Seiter, Kenneth
 Sherrill, William M. Jr.
 Short, Bradley Mark
 Smith, Gerald P.
 Smith, Kent
 Smith, Terrald J.
 Snider, James R.
 Stewart, Jerry R.
 Stewart, John B.
 Stillwell, Mark
 Studt, James
 Swicegood, John R.
 Taft, Eileen
 Taft, Eric
 Teeter, Mark
 Thompson, Robert J.
 Turner, William F.
 Van Asche, Christopher
 Vanderpool, Roy E.
 Vernon, Rowland P. Jr.
 Waack, Timothy
 Wahman, Gerald E.
 Wallace, Kenneth K.
 Webb, William K.
 Weisse, John J.
 Wells, John D.
 Westbrook, Michael R.
 Westermann, Norman F.
 Whitaker, John
 Wikman, John H.
 Wills, Paul I.
 Wilson, Morton C.
 Wolfe, Michael S.
 Woods, Leon P.
 Zufari, Munir M.

Sevier County

Buffington, Mike
 Gonzalez, Floyd
 Hoyt, Jonathan
 Jones, Charles N.
 Jones, Thomas
 Opiela, Jaroslaw P.
 Richards, Juan Carlos
 Stearns, David E.
 Vogan, Cheryl L.

St. Francis County

Collins, E. Morgan Jr.
 Conner, George
 Fong, Fun Hung
 Hammons, Edward P. #
 Kumar, Sudhir
 Matthews, Seniors
 Meredith, James Jr.
 Miller, Matthew W.

Patton, W. Curtis
Salvador, Ester Arejola
Schwartz, Frank R.

Tri County (Sharp, Iazard, Fulton)

Arnold, Carl
Arnold, Griffin II
Bozeman, Jim G.
Campos, Louis
Dibrell, Fredrick
Grasse, A. Meryl
Jackson, George W.
Krygier, Albin J. #
Lane, Robert C.
Moody, Michael N.
Phillips, Rebecca
Relyea, William V.
Sra, Surinder Paul
Tatum, Harold M.
Tucker, Charles L.
Varela, Charles D.
Williams, Robert S.
Wright, Donald

Union County

Allen, David Eugene
Anaya, Carlos
Anreder, Michael Barry
Anzalone, Gary
Arceneaux, Matt
Barenberg, Andrew
Bevill, Gary L.
Booker, J. Gregory
Bryant, D'Orsay III
Carroll, Peter J.
Cyphers, Charles D.
Daniels, C. Dwayne
Davis, Richard K.
Deere, Joy
Dietzen, Richard E.
Dixon, R. Mark
Duzan, Kenneth R.
Edmondson, C. Douglas
Elliott, Wayne G.
Ellis, Jacob P.
Fonticiella, Aldo V.
Forward, Robert B.
Fraser, David B.
Germann, Robert E.
Giller, W. John Jr.
Gomez, Henry L.
Hill, Grady Jr.
Holleran, John R.
Hopson, Deanna
Jenkins, Chester W.
Jones, Steve A.
Lucas, Diana T.

Lucas, John J.
Kang, Gurprem Singh
King, Billy D.
Kinslow, Ivory
Landers, Gardner H.
Massanelli, Gregg L.
Menendez, Moises A.
Mohan, Kumaran K.
Murfee, Robert M.
Ong, Tie S.
Pillsbury, Richard C.
Pirnique, Allan S.
Posey, Willie II
Ratcliff, John
Ray, Robin Phinney
Rogers, Henry B.
Sample, Dorothy C.
Sarnicki, Joseph
Schonefeld, Michael D.
Schultz, Wayne H.
Scurlock, William R.
Seale, James E. Jr.
Shah, Asim Ahmed
Smith, George W.
Stevens, Willis M. Jr.
Talley, H. Aubry
Tolosa, Elizabeth
Tommey, C. E.
Tommey, Robert C.
Turnbow, R. L.
Ulmer, Minna I.
Vogenitz, William
Warren, George W.
Watson, Donya
Watson, Robert A.
Weedman, James B.
Williamson, John R.
Wilson, Larkin M. Jr.
Yocum, David M. Jr.
Zahniser, Donna J.

Van Buren County

Belizario, Marcelino C.
Hall, John A.
Pearce, Charles G.
Pineau, Gregory Philip
Starnes, Harry

Washington County

Albright, Spencer III
Allen, B. Eual
Applegate, C. Stanley Jr.
Arnold, James A.
Atwood, H. Daniel
Bailey, Donald C.
Bailey, Scott
Baker, C. Murl Jr.
Baker, Donald B.

Beck, J. Thaddeus
Beck, William A.
Beckman, James Jr.
Billingsley, John A. III
Blankenship, James B.
Bonner, Mark
Box, Ivan H.
Boyce, John M.
Bredfeldt, Raymond
Brooks, D. Wayne
Brooks, W. Ely
Brown, Bruce B. Jr. #
Brown, Craig
Brown, David L.
Brunner, John A. III
Burnside, Wade W. Jr.
Burton, Anthony R.
Butler, G. Harrison
Cannon, R. David
Carver, Joel D.
Chase, Patrick R.
Cherry, James F.
Churchill, David
Clouatre, Michael Paul
Coker, Tom P.
Coker, Tom Patrick
Cole, George R. Jr.
Cooper, Craig
Councille, Clifford C. Jr.
Crittenden, David R.
Crocker, Thermon R.
Cross, Michael J.
Cunningham, Darrin D.
Danks, Kelly R.
Davis, David A.
Davis, Randall
Decker, Harold
Deen, Lewis S.
Dodson, C. Dwight
Duke, David D.
Duncan, Philip E.
Dykman, Thomas R.
Eck, Gareth
Edmondson, Charles T.
Embry, Travis D.
Endsley, Charolette
Ferguson, Susan Portis
Fincher, G. Glen
Fink, Roger Lee II
Fish, Ted J.
Fossey, Carol
Gardner, Buford M.
Garibaldi, Byron T.
Garner, Hershel H.
Ginger, John D.
Gray, Dalton L. II
Grear, Danna
Green, Michael D.

Grote, Walton
Gyles, Nicholas R. II
Haisten, James
Hall, Ben
Hall, Joe B.
Hamilton, Herbert E.
Harris, David Jay
Harris, Murray
Harris, Paul L.
Harris, W. Duke
Harrison, William F.
Hart, Hamilton R.
Hayward, Malcolm L. Jr.
Hedberg, Curtis
Heinzelmann, Peter R.
Hendrycy, Paul R.
Henry, Morriss M.
Henry, Paul M.
Higginbotham, Hugh B.
Higginbotham, William
Hoffman, Carl E.
Hollomon, Michael
Hui, Anthony
Hurlbut, Kevin
Hutson, Martha
Hutson, Sanford E. III
Inlow, Charles W.
Jay, Gilbert D. III
Johnson, Brad D.
Johnson, Miles M.
Knox, D. Luke
Koehn, Laura J.
Kraichoke, Saran
Lloyd, Richard A.
Loftin, Teresa D.
Magness, C. R.
Mahan, Meredith
Martin, F. Allan
Martin, William C.
Mashburn, James D.
McAlister, Joseph H.
McAlister, Mitchell
McBee, Sara
McDonald, James E. II
McElroy, Kellye
McEvoy, Francis
McGhee, Linda M.
McGowan, William
McNair, William R.
Miller, Charles H.
Miller, George
Miller, Mark E.
Mills, William C. III
Mitchell, Banford R. Jr.
Moon, Steven L.
Moore, James F.
Moose, John I.
Morse, Michael

Murry, J. Warren
 Nettleship, Mae B.
 Nowlin, William B.
 Ortego, Terryl J.
 Pang, Robert R.
 Park, John P.
 Parker, Lee B. Jr.
 Patrick, James K.
 Pearson, Fran
 Pesnell, Larkus H.
 Pichoff, Bruce Edward
 Pickett, James D.
 Pickhardt, Mark G.
 Pope, Kevin L.
 Powell, Mark W.
 Power, John R.
 Proffitt, Danny L.
 Raben, C. A. Tony
 Riddick, Earl B. Jr.
 Riner, Dan M.
 Rogerson, Susan H.
 Romine, James C.
 Rosenzweig, Kenneth
 Ross, Joseph
 Rouse, Joe P.
 Runnels, Vincent B.
 Saitta, Michael R.
 Sandefur, Barbara A.
 Sanders, Scott
 Sandler, Richard
 Schemel, Lawrence J.
 Schmidt, Clinton C.
 Sexton, Giles A.
 Sexton, Jon A.
 Shaddox, T. Stephen
 Sharkey, Martha Ann
 Sharp, Jim D.
 Siegel, Lawrence H.
 Simmons, Thomas
 Simpson, Todd R.
 Singleton, E. Mitchell
 Sisco, Charles P.
 Smith, Austin C.
 Snyder, Norman I.
 St. Clair, Kevin
 Stagg, Stephen W.
 Taylor, Robert G.
 Tellez, Guillermo J.
 Thomas, Joanna M.
 Thorn, Garland M. Jr.
 Titus, Janet L.
 Tomlinson, Robert J. Jr.
 Tuttle, Larry D.
 Ureckis, David
 Weed, Wendell W.
 Weiss, John B.
 Wheat, Ed Jr.
 Whiteley, Andre

Whiting, Tom D.
 Williams, John R.
 Wood, Jack A.
 Wood, Russell Hunter
 Wood, Stephen T.

White County

Asmar, Salomon
 Baker, Ronald L.
 Ballinger, Phillip Scott
 Bell, John
 Blakely, Brent M.
 Blickenstaff, Kyle R.
 Blue, Glen T.
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 Brown, Arnold R.
 Brown, Mark A.
 Brown, Peggy J.
 Burns, Jerry
 Citty, Jim C.
 Collier, Steven F.
 Covey, David C.
 Davidson, Daniel
 Dicus, G. Scott
 Dugger, Joseph S.
 Elliott, Robert E.
 Fincher, S. Clark
 Formby, Thomas A.
 Gardner, Jack R.
 Gibbs, William M. III
 Golleher, James H.
 Hannah, J. Todd
 Hatfield, David L.
 Henderson, John C.
 Holston, John S.
 Jackson, Clarence W.
 Johnson, David M.
 Joseph, Eugene A.
 Justus, Michael G.
 Killough, Larry R.
 Kinley, J. Garrett
 Koch, Clarence W. Jr.
 Lefler, Stephen F.
 Lewing, Hugh S.
 Lewis, James Sheridan
 Lowery, Benjamin R.
 Lowery, Robert D.
 McAdams, Edward L.
 McCoy, James R.
 Meacham, Kenneth R.
 Millstein, David I.
 Moore, Donald
 Moore, Jesse
 Muirhead, Michael J.
 Nevins, William H.
 Norris, E. Lloyd
 Payne, Cheryl
 Pope, Tammy

Rains, Jeffrey
 Ramirez, Raul
 Ransom, C. E. Jr.
 Riddick, Robert S.
 Risinger, Melanie W.
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 Sanchez-Montserrat, Rafael
 Schwartz, Stanley S.
 Shultz, Sam L.
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 Smith, Bernard C.
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 Thompson, Bruce
 Weathers, Larry W.
 White, Bradley
 White, William M.
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 Young, Jack S. III

Woodruff County

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Yell County

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 Adametz, John Jr.
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 Thompson, Jerome W.
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 Williams, Debra
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 Wilson, Robert B. Jr.
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 Wren, Mark
 Wren, Mary
 Wyatt, D. Neal
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 Banks, Holli N.
 Barden, Michael G.
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 Barr, Susan
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 Beck, David
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 Bennett, Leigh A.
 Bess, Barbara
 Bhattacharyya, Debasish
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 Borg, Clayton D.

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 Cullen, Robert D.
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 Dannaway, Douglas C.
 Dare, Jason A.
 Darwin, Amy L.
 Daugherty, Jeremy
 Daut, Peter M.
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 DeMent, William T.
 DeWitt, Keitha R.
 Dennington, Elvin L.
 Denton, Meredith
 Depko, Joshua M.
 Deuter, Brian E.
 Dickinson, Jacob
 Diemer, Heather M.
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 Dopkou, Joshua
 Dougals, Mary F.
 Downen, Brian
 Duffy, Laura
 Dunn, Jeremy
 Dwyer, R. Gregg
 Dye, Daniel
 Dyer, Mark Alan
 Earl, K. Sam
 Easley, Seth
 Ebert, Robert H.
 Edwards, Angela S.
 Edwards, Clinton B.
 Ellis, Michael
 Engle, David B.
 Evans, Clinton E.
 Evans, Melia
 Faddis, Lance A.
 Farrar, Jason
 Felton, Daniel H. IV
 Ferguson, Philip E.
 Finkbeiner, Andrew A.
 Fletcher, Brent F.
 Fletcher, Terry
 Flowers, Rebekah
 Fong, Shirley
 Fore, Daniel B.
 Forrest, Robert P.
 Fox, Patrick J.
 France, Vianne R.
 Frederick, John T.
 Frego, Jonathan L.
 Fuller, Jon D.
 Gardial, Paul
 Garrett-Shaver, Martha G.
 Gaston, Caleb O.
 Gathright, Kenneth
 George, Matthew S.
 Geren, Blake
 Glover, Forrest D.
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 Goodman, Brian
 Goodwin, Whit
 Goosby, Nova D.
 Gordin, Audrey L.
 Gordon, Eric H.
 Graham, Jeffrey B.

- Gray, Rickey C.
 Green, Edward D.
 Guptz, Ramona
 Gustafson, Craig A.
 Halter, Steven J.
 Haltom, John
 Hannon, Martin
 Hardin, Laura A.
 Hardin, Ronald Jr.
 Harris, Bryson C.
 Harris, Dehra A.
 Harrison, Marla K.
 Harton, Scott
 Hawkins, William L.
 Hayes, William J.
 Hearyman, Marty W.
 Heinzelmann, Andrew D.
 Hendren, Ryan L.
 Hendrickson, Blair L.
 Henriksen, John
 Henry, Lance B.
 Herrin, Kathy J.
 Hillis, Thomas M.
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 Hinton, Richard W.
 Hoang, Thuy T.
 Hodges, Anissa
 Hogan, W. McCall Jr.
 Holden, James R.
 Holland, Cheryl
 Holt, Brent E.
 Howard, Don N.
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 Hughes, Angela
 Hughes, Bradley R.
 Hunt, James
 Hunt, Justin
 Hurt, Jason W.
 Hussain, Tanvir
 Hutton, Theron
 Ison, Keith A.
 Jansen, Joe
 Jansen, Stephen
 Jarrard, Kristin A.
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 Jennings, Bryan T.
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 Johnson, Brad R.
 Johnson, David G.
 Johnson, Dwight J.
 Johnson, Jeff
 Jones, Bridgette L.
 Jones, David G.
 Jones, Sherri
 Jones, Steven S.
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 Jordan, Barry
 Kaakaji, Rami
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 Keels, Tansyla D.
 Kelley, Morris E.
 Kelly, Derek
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 Kim, Peter J.
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 King, Kristy S.
 Kirby, Deborah
 Kit, Brian K.
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 Klutts, James S.
 Knott, Kyle
 Koffler, Molly
 Koroma, Donna-Marie
 Koury, Jadd W.
 Krenn, Louis P.
 Krepps, Brett
 Kueter, Daniel B.
 Kuykendall, Tracy
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 LaRue, Oakley
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 Lambeida, Juan
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 Latch, Rebecca L.
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 Layton, Billy J.
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 LeDay, Romona
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 Love, Monica
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 Lyle, C. Wayne
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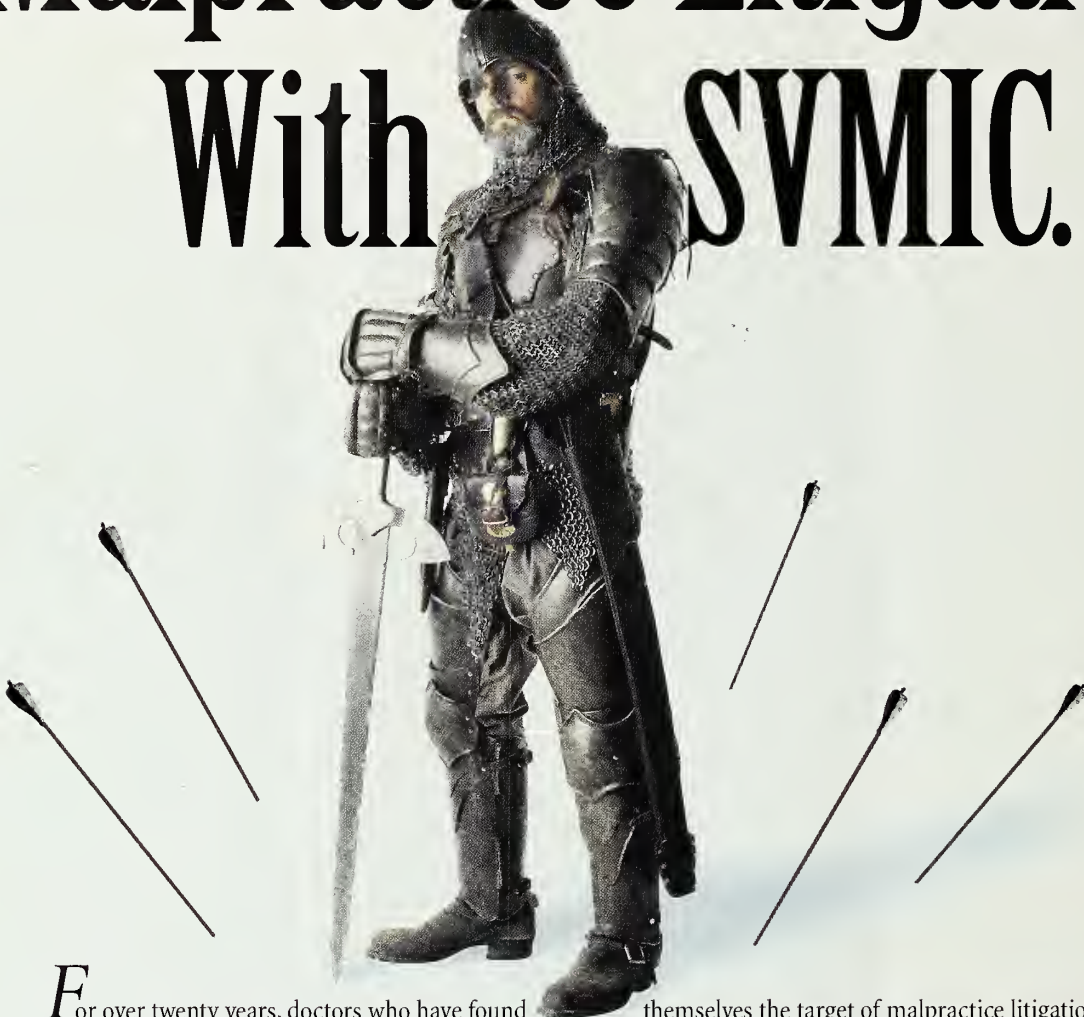
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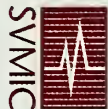
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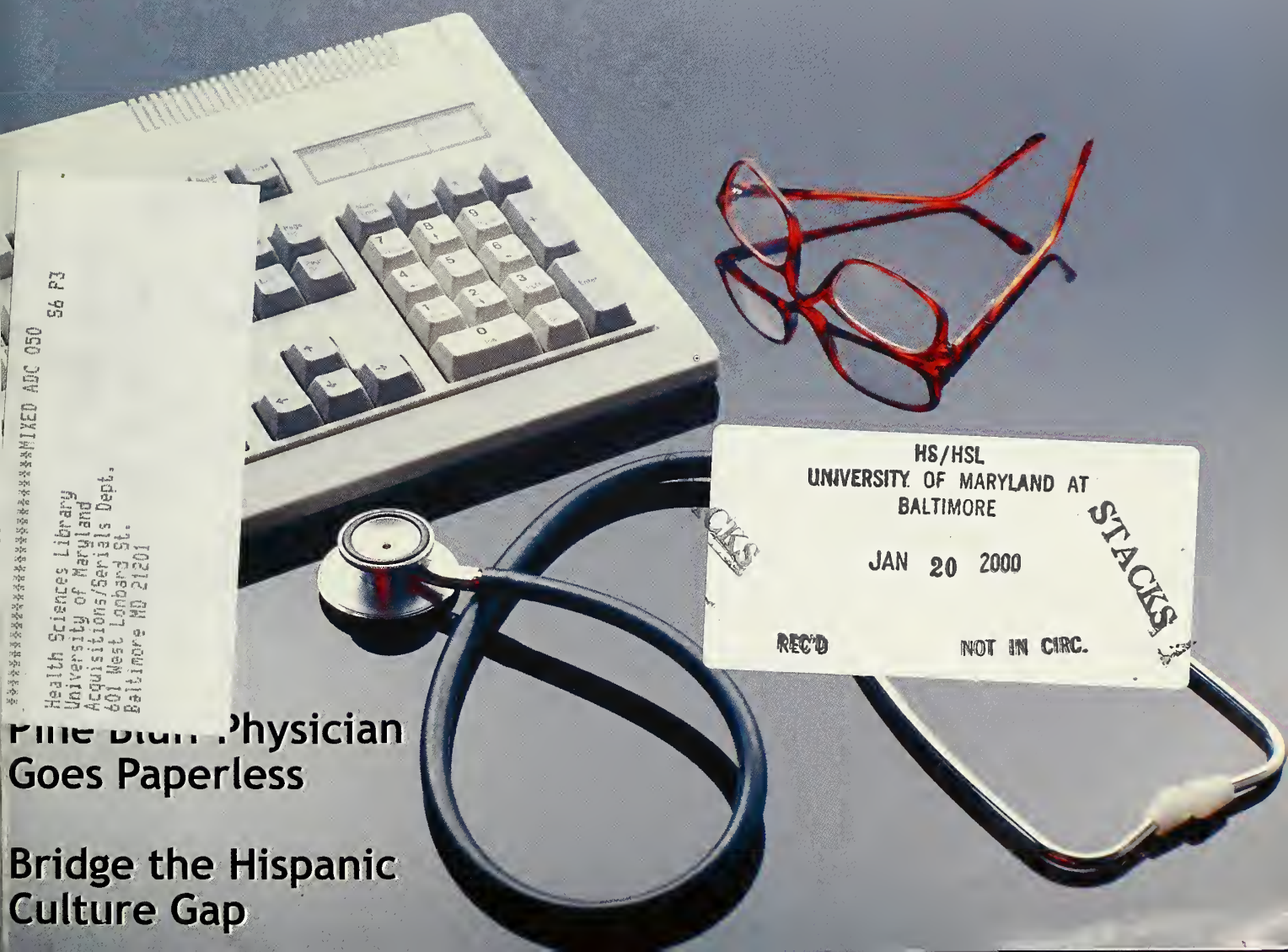
Vol. 96 No. 8

January 2000

Special Report:

Health Care on the Line

Doctors Deliver Via E-Mail



Pine Bluff Physician
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Bridge the Hispanic
Culture Gap



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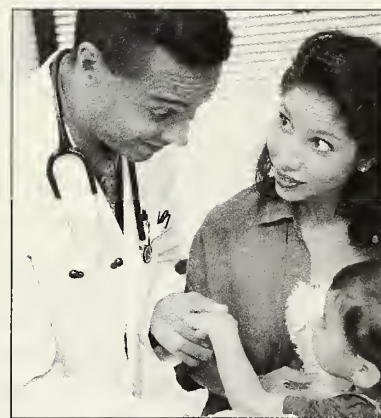
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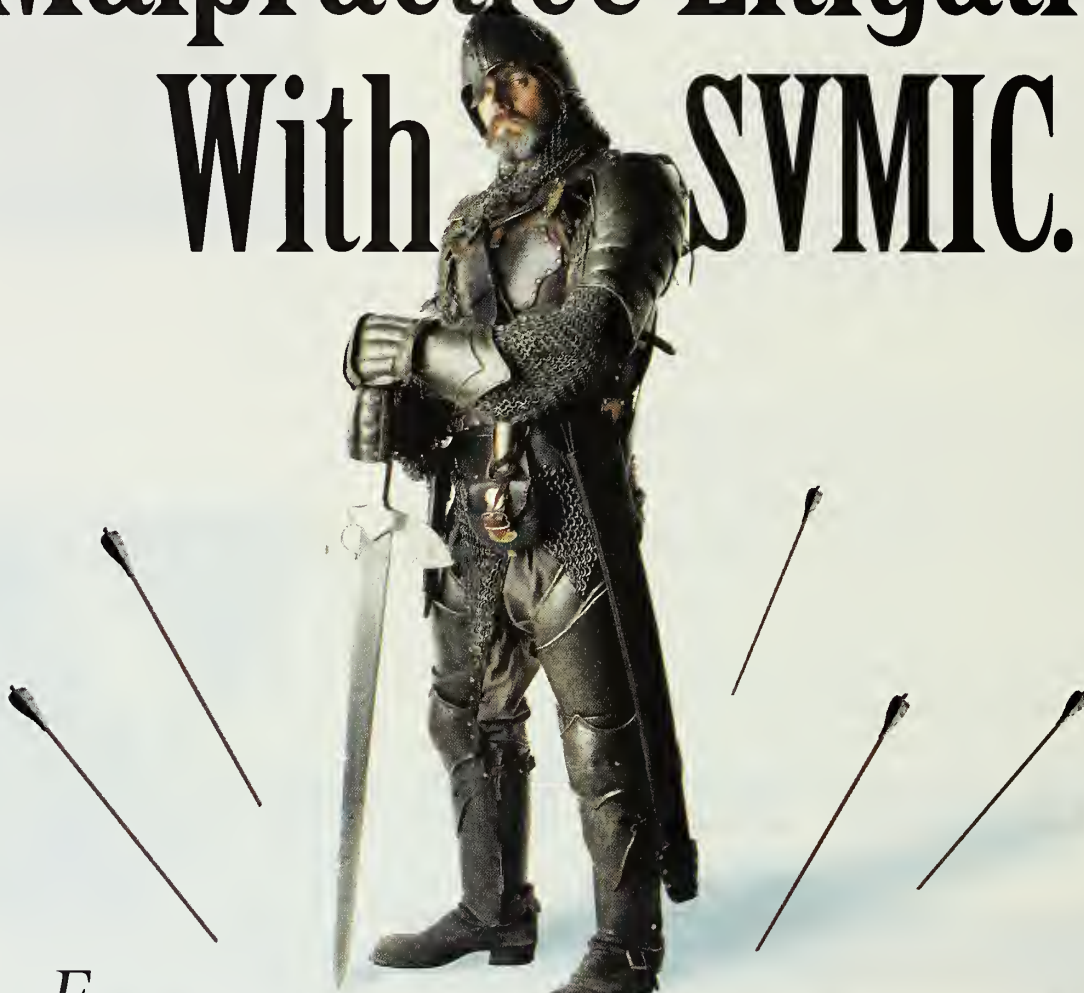
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With Arkansas' growing Hispanic population, it's important for physicians to be sensitive to the culture.

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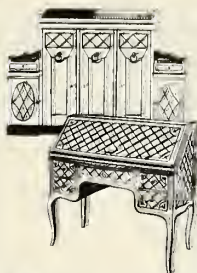
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COMMENTARY



Heavy Furniture

LEE ABEL, MD

The first thing she said to me as I entered the exam room was, "I know why my blood pressure is up."

Mrs. Smith is in her 70s and has multiple health problems. She also has been under a lot of stress, mostly because of the ill health of her mother, who was unhappy and complained chronically. Mrs. Smith was often exhausted from trying to meet all her mother's requests.

I found out that her mother had recently died, which was not unexpected since her mother's physician had thought she would die a decade earlier. Mrs. Smith told me her blood pressure was high because of what had happened to all her mother's furniture. Although her mother was living in a nursing home at the end of her life, her house was unsold and its furnishings intact. At the time of the mother's death, Mrs. Smith's sister-in-law had taken most of the furniture and sold the rest without consulting or informing Mrs. Smith. Mrs. Smith was angry. She was so upset she couldn't sleep. She was going to see a lawyer.

Mrs. Smith poured out this story to me. It wasn't just about furniture, of course. It was about betrayal, injustice and not getting gratitude for all she had done. Maybe she wanted me to take her side and agree she was a victim. But what I think she needed — and deep down wanted — was to be heard, to be understood and to be appreciated for all she had done for her mother despite her own health problems.

The story also was about an unfounded anxiety that maybe she could have done even more for her mother. It was about guilt for the deep relief she had felt when her mother died. It was about the sadness and finality of losing her mother. It was about what her mother's death meant to her own life. It's scary to lose a parent, even when that parent is very old and has been sick for a long time. It breaks through the fantasy we have that the cycle of life will somehow be suspended for us. Our own mortality becomes very real.

Mrs. Smith didn't need me to increase her blood pressure medicines or give her an anti-anxiety drug or a sleeping pill. Yet, I was aware of an urge to do one of those things. I seem to feel that listening is not enough. This is a widespread attitude in our society, and among physicians it's reinforced by our narrow technical training. Mrs. Smith's anger and grief weren't amenable to any quick fix, but there were comical aspects to the situation. Her sister-in-law (also in her 70s) was behaving suspiciously like a 4-year-old. It was funny to imagine the sister-in-law's house so full of furniture there was no place to walk. The house so crowded that there was no room to open the drawers on the chest of drawers. Chairs overflowing out the windows; armoires blocking the doors.

What would it be like to be in your 70s and act in such a covetous and grasping manner? Most of us long before that age are drowning in "stuff." Most of us also have learned that stuff doesn't make us happy for very long. Being human we often forget. The sister-in-law would not find real joy in all that furniture. And Mrs. Smith would not find real peace in the courtroom.

It is curious how our patients can bring us gifts unawares. Mrs. Smith's story was an invitation to examine the ways in which I can be grasping. It was an invitation to see the part of me that would be a victim. It was an invitation to remember what is truly important. ■

Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic. He is a member of the editorial board of *The Journal of the Arkansas Medical Society*.

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Physicians Gain Ground in Prompt Payment Battle

By DAVID WROTEN

As this issue of *The Journal* goes to print, we have just returned from a legislative hearing where Insurance Commissioner Mike Pickens was grilled for nearly two hours on his plans to address the problem of prompt payment. The message was loud and clear — this is an issue that has captured the attention of the legislature and they are demanding a solution.

To Commissioner Pickens' credit, he has drafted a new prompt payment rule that will make it more difficult for health insurance companies to delay payment. The Arkansas Medical Society has worked with the Arkansas Department of Insurance and others during the past six months to draft the proposal. While it comes up short in a couple of key areas, overall the proposed rule (Rule and Regulation 43) is a great start.

The good news is the rule requires carriers to process "clean" claims in 30 calendar days or less. If the claim is not a "clean" claim, the carrier must request the additional information within 10 days and must specify exactly what is needed. After receiving the information, the carrier must make a decision within 45 calendar days. The rule defines a clean claim and prohibits repetitious requests simply to delay payment. This is a major change in current regulations and a major victory for physicians and their patients.

The proposal requires carriers to file quarterly reports with the department that will be used to produce a "report card" on claims paying practices. It also contains provisions relating to pre-certification, pre-authorization and prompt "medical peer review" for denials.

What's missing? The rule still doesn't allow health care providers to file complaints with the department. However, the commissioner is encouraging providers to notify the department of problems by use of a "health care provider information form." The rule also doesn't provide any penalties on a per-claim basis. To run afoul of the rule, the carrier must be found to exhibit a pattern or general practice of violating the rule. Physicians, patients and the AMS will need to work together to bring these problems to the attention of the insurance department.

While not in the regulation, the commissioner has announced the formation of a "Health Insurance Claim Coordination and Resolution Committee." The purpose of this committee will be to discuss and debate health claim payment problems and work toward ways to solve these problems particularly as they relate to prompt payment.

Finally, a word of caution. The rule contains strong penalties against health maintenance organizations whose contracted providers balance bill patients in violation of a hold harmless clause. The department has received complaints from patients who have been turned over to collection agencies for failure to pay a bill owed not by the patient, but by the HMO. Penalties range up to \$2,000 per incidence and up to \$10,000 per incidence if the violation is intentional. If an HMO is fined because one of their physicians or hospitals balance bills a patient and that patient files a complaint, expect the HMO to retaliate by de-selecting that provider immediately.

The regulation has a planned implementation date of March 1, 2000. While legislation may still be needed to enact penalties and standing to file complaints, the proposal deserves a chance to prove it can work. Likewise, Commissioner Pickens and his staff deserve credit for moving forward on resolving this problem. ■



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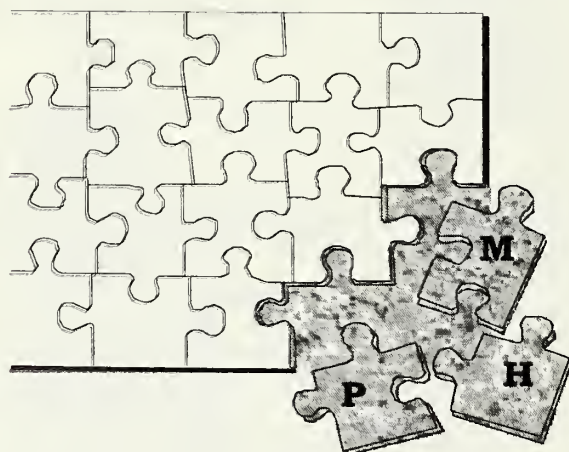


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DAYS GONE BY

President's Address

Like the people in Boccaccio's narrative, we have literally "fled from the plague" to hold this, our annual meeting, under the classic shades of Fayetteville, the Athens of Arkansas! The coincidence at least of the fleeing is so striking, and especially that we, a company of learned medical men, should after centuries be debarred from meeting where we please, by an infectious and contagious epidemic disease, that probably prevailed in China centuries before the birth of Christ, and afterwards, denominated by Galen's day the "Pesta Magna," a disease which, after great pestilential voyages all over the world, has been brought down, in the last few years, to a death rate of less than 2 percent by thorough vaccination. Many physicians had never treated a case until this present epidemic, and for nearly a generation the disease was practically unknown in many parts of our country; vaccination even in the larger towns was neglected. In the present epidemic great confusion has arisen in some parts of our state over the diagnosis of the disease. There is no royal road to diagnosis; the most brilliant and the most successful diagnosticians are those who are the most patient, painstaking and who work out their diagnosis by the symptoms present and the visible signs, and excluding what the patient might have but the full development of the disease proves, that he has not. The history of exposure; the incubation; the onset with chill, high fever, intense pain in head, back and loins; the red rash; the papular vesicular and pustular stages; the formation of crusts, the desquamation, leaving bright shining eschar, with or without pits, the fever falls when the eruption appears to rise again in the pustular stage from anto-intoxication by pus absorption — could there be a more classical picture to any disease! The different stages and the average duration and symptoms of each! It is in the obscurity of the differential diagnosis at times that the most accomplished physician may be positively unable for one, two or three days even to make a positive diagnosis. ■

Reprinted from the "Proceedings of the 25th AMS Annual Session," May 1900.

IN + THE + NEWS



Heart Hospital Among Winners

Arkansas Heart Hospital recently was listed among winners of the National Research Corporation's 1999 Consumer Choice Heart Care Services Award. It is the only hospital in Arkansas to receive the award.

The NRC bases the awards on responses from 170,000 households in 48 contiguous states and the District of Columbia. The award was given to 124 hospitals in 109 metropolitan areas.

"This honor further validates the vision we had in the beginning, that this hospital was needed and wanted by the community," said Dr. Bruce Murphy, a cardiologist and medical director of Arkansas Heart Hospital. "We believed there was a better way to provide heart care and now the people of the Little Rock community have told us they agree."



High-Alert Drugs Identified by Study

The Joint Commission on Accreditation of Healthcare Organizations recently issued

a report concerning high-alert medications.

Based on a study by the Institute for Safe Medication Practices conducted during 1995-96, five medications were identified as having the highest risk of causing injury when misused. The top five are insulin, opiates and narcotics, injectable potassium chloride or phosphate concentrate, intravenous anticoagulants (heparin) and sodium chloride solutions greater than 0.9 percent.



AMA to Contribute to New Web Site

The American Medical Association and six medical specialty societies will contribute their expertise to www.medem.com, a web site that will offer health information beginning early in 2000.

The name of the site is short for "medical empowerment." It's designed to deliver peer-reviewed health care information to millions of Americans. Medem.com helps the AMA fulfill its mandate to provide leadership in the world of digital health care. In addition to being approved by the AMA's Corporate Review Team, the proposal has been reviewed thoroughly by the AMA Board of Trustees.

Viagra Market Grows on 'Net

According to a study published in the *New England Journal of Medicine*, Viagra (sildenafil) is extensively sold on the Internet.

The study, conducted during April and May 1999, identified 77 web sites that offered Viagra to consumers. Medical information about Viagra was available from 55% of the sites. About the same percentage required consumers to fill out a medical questionnaire, although 35% of those questionnaires are reviewed by physicians.

Half the sites asked whether the consumer had erectile dysfunction and 44% required information about nitrates. Most sites required that consumers release companies from liability.

By the way, the average cost of a 50-milligram Viagra tablet was \$12.60.



Study Gives Edge to Angioplasty

An analysis of studies that compare immediate angioplasty or thrombolytic therapy for myocardial infarction patients shows that one-month outcomes appear more favorable with angioplasty, according to a report in the Massachusetts Medical Society's *Journal Watch*.

Dutch researchers updated the results of a trial in which 395 patients with acute myocardial infarction were randomized to primary angioplasty or thrombolytic therapy with streptokinase because longer-term outcomes were in question.

With an average follow-up of five years, mortality was significantly lower in the angioplasty group (13% vs. 24%); the difference was entirely explained by reduced cardiac mortality. The angioplasty group also had lower rates of nonfatal reinfarction (6% vs. 22%), additional angioplasty (26% vs. 52%) and hospital readmissions for ischemia or heart failure.

Fitness Can Predict Postoperative Health Conditions

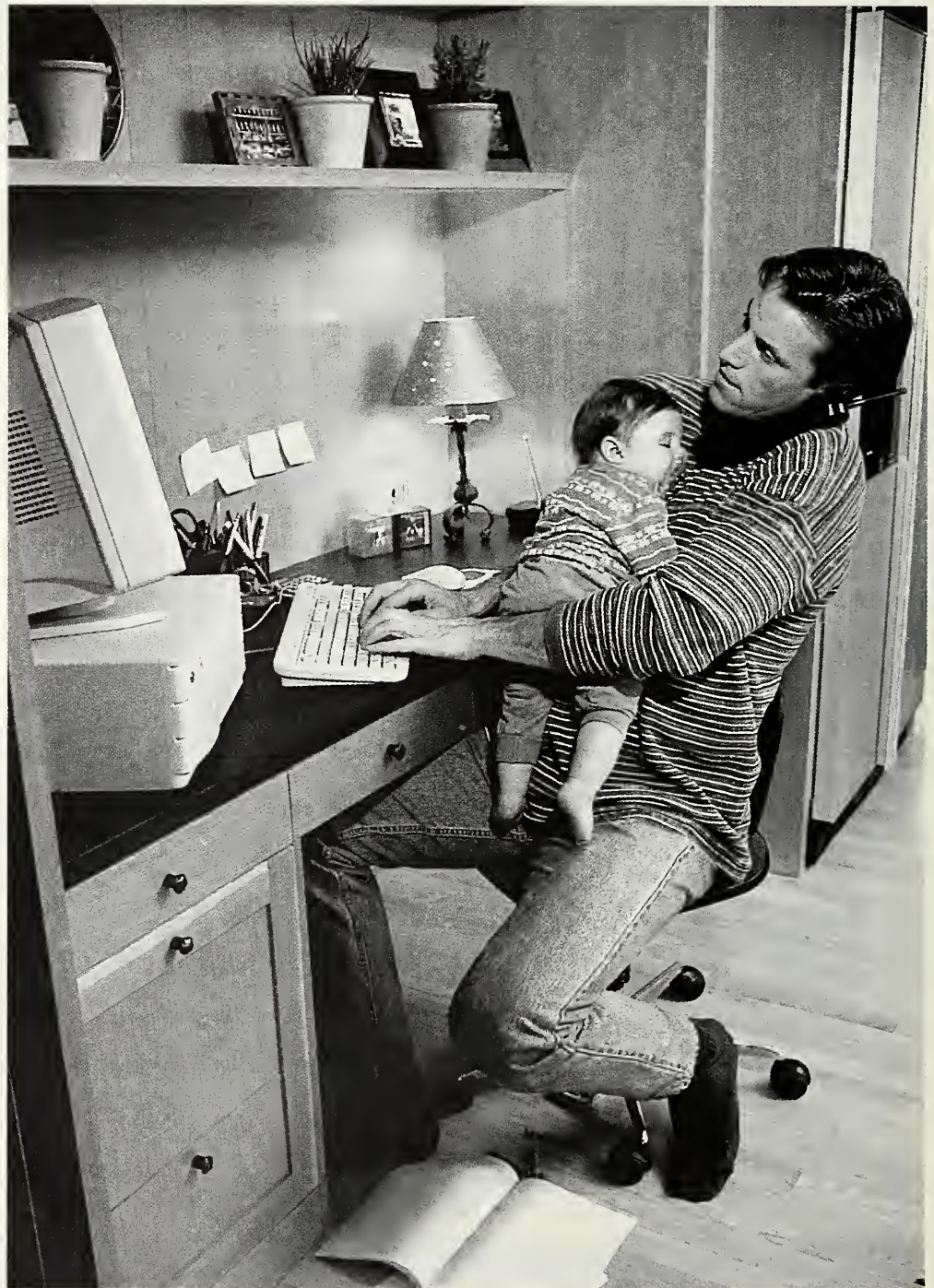
Researchers in Seattle have found that poor exercise tolerance predicts postoperative complications, although formal exercise testing is expensive, time-consuming and infrequently performed before operations.

The Seattle study included 600 consecutive patients who received preoperative evaluations for major noncardiac surgery. Patients with poor exercise tolerance had a significantly greater risk for serious complications than those with good exercise tolerance (20.4% vs. 10.4%). ■

E-Doc Approach Opens Lines to Patients

Some Physicians Against Using Computers for Medical Care

**Through e-mail
a person could
communicate a
problem to a
physician and
receive advice
that could
either prevent
the need for a
physical exam
or allow the
patient to
make an
informed
choice about
a health
problem.**



Dr. Charles W. Smith, medical director at University Hospital, is working with the Arkansas BioVentures program at the University of Arkansas for Medical Sciences (where he's an associate dean), to find a market for his e-mail physician correspondence creation.

The program differs from other health information and medical advice expanding on the Internet because it is set up on a contractual basis between physicians and, in this case, Acxiom Corp. Officials stress the program is not to be used as a substitute for a relationship between a patient and a physician.

Since January 1999, Acxiom's 2,000 Arkansas employees have been able to ask medical questions or obtain health information through the "e-doc" program. Employees e-mail their questions to the doctors and are guaranteed a response within 24 hours.

"Doctor," writes one Acxiom employee, "I'm a little concerned about a possible ear infection." The employee lists the symptoms, including "little popping sounds when I swallow" during air travel.

Within 24 hours, Dr. Smith sends a reply, saying the problem sounds like an ear infection, which can result from either the residual effects of an upper respiratory infection or nasal allergies. He adds two short-term ways to deal with the problem: forcing air into the middle ear by holding the nose and swallowing, or taking a decongestant/antihistamine.

If there is a history of nasal allergy, writes Dr. Smith, "you might want to write back and we can discuss other options that are available for treatment." He also includes an Internet link to a health information site at the University of Illinois that explains the purpose of the part of the ear in question and explains how an infection occurs.

No trip to the doctor's office was necessary, no long wait for a five-minute exam that would result in probably the same diagnosis along with a bill. Dr. Smith says the program is a way to ex-

pand health care access using technology.

OUT OF THE NORM

This particular combination of technology and health care is troubling to Dr. Ray Jouett, chairman of the Arkansas State Medical Board.

"The practice of medicine by telephone has never been recognized as a way to practice quality medicine," said Dr. Jouett. "In essence that's kind of what you're doing here. The potential pitfalls are enormous."

Dr. Jouett, who began his practice as a neurological surgeon in 1955 and retired in 1994, says supplying information is one thing but, "to be making a diagnosis by e-mail and sending prescriptions with no follow-up — that, to me, is certainly not quality medicine."

"We've got these alternative methods in place, and I'm not sure that you can justify this sort of [e-mail] practice. We're seeing a two-tiered system of health care delivery evolving in this state and now we're developing another tier where the physician never sees the patient."

— Dr. Ray Jouett

Arkansas State Medical Board

"I think that all physicians call a prescription in on a patient at times," Jouett said, "but they have a history of that patient and then there's always a follow-up requested as well, and certainly that's reasonable."

Dr. Jouett acknowledges that the practice is spreading.

"Obviously this is something that must be going on across the country and this may well be what we're going to. Still, in my estimation, this is not the way to practice good medicine."

Nurse practitioners and physicians' assistants already offer alternatives to traditional medicine in Arkansas, Dr. Jouett points out.

"We've got these alternative methods in place, and I'm not sure that you can justify this sort of [e-mail] practice. We're seeing a two-tiered system of health care delivery evolving in this state and now we're developing another tier where the physician never sees the patient."

"I do not believe this will be received favorably by the physicians of the state because they already do everything they know to cut down costs in medicine. There are no shortcuts to quality medicine. I think the patient is in a position to suffer with this sort of care."

SKEPTICAL AT THE START

"At first, I was very skeptical," said Carla Blackwell, who handles health benefits for Acxiom.

During the setup phase, Blackwell worked with Dr. Smith to tailor the pro-

gram for Acxiom. A contract with the company addresses liability, cost and other issues raised by Blackwell, who is now a strong believer in e-doc.

She sees it as a way for employees to make more informed decisions on health matters, including whether to see their doctors. The long-term goal for the program is to reduce employee health care costs.

Meanwhile, Dr. Smith is talking with other companies interested in the program. He is working on a password-protected Internet site for the program. It will be an extension of the e-mail offering, with links to informative health sites and information about common problems.

Dr. Smith said he started considering the program about two years ago when he was using e-mail at work. "I began thinking there had to be a way to make medical care more convenient through technology."

Through e-mail, he reasoned, a person could communicate a problem to a physician and receive advice that could either prevent the need for a physical exam or allow the patient to make an informed choice about a health problem. It increases access to health care information, he says, and provides a format for finding answers to health problems before they escalate.

Dr. Smith said the most common questions concern flu or allergies. Some users have asked for prescription refills to bridge the time until a doctor's appointment; others have asked for information about a disease or obscure illness that a friend or family member may be suffering.

From the employer's perspective, it allows employees to stay on the job, Dr. Smith said. Such a program also could be seen as a tool for employee recruitment.

SETTING UP THE LOGISTICS

Liability was the first concern for Blackwell and Acxiom executives.

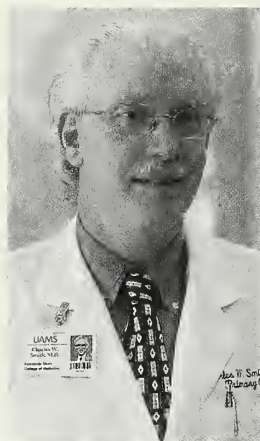
Employees must sign up to participate in the program and sign a waiver. The waiver stresses that e-doc is not for emergencies.

"It is only for problems that can wait 24 hours for an answer," Dr. Smith said.

Cost also was a factor. Blackwell says the question was whether one e-mail should be considered an office visit or handled on a per-problem basis since it often takes a couple of messages to address one problem.

Although other companies might set up the program a different way, Blackwell said, Acxiom contracted to charge on a per-problem basis.

A small test group was set up for the program in 1998. After six months the



"It's not our intent to take over the role of a primary care physician. Frequently my answer might well be that you need to go see a doctor."

**— Dr. Charles Smith
UAMS**

company surveyed the group to determine usage and whether employees thought the program was beneficial.

"Overwhelmingly, the response was very positive," Blackwell said.

A larger test group came next, with about 500 employees from a cross section of the company. Again, the response was positive. Dr. Smith says he has received several thank-you notes from employees.

The three to 10 questions Dr. Smith receives each day take him, at most, a couple of hours to research and answer. Two other physicians answer questions, too.

"It's not our intent to take over the role of a primary care physician," Dr. Smith reiterated. "Frequently my answer might well be that you need to go see a doctor."

Dr. Smith says e-doc also is not an avenue for people to access inappropriate drugs or medications. The doctors are "very conservative" in refilling a prescription and will not do so without "adequate information," he says.

One major difference between e-doc and many of the health care sites that are proliferating on the Internet is the affiliation with a university rather than a private company. Also, the program is offered within the context of a company's benefit plan and by contract between UAMS and the company.

Dr. Smith and Acxiom are gathering data on usage and say it's too early to spot any trends or determine whether the program is saving health care costs. Also monitored will be employee health

costs before and after the program began, time away from work and disease-specific data about how employees are able to manage illness with the information received via e-doc.

Blackwell says the program has been successful so far. Asked if she thinks e-doc could succeed at reducing health care costs, she answered, "Oh, definitely."

She notes that she is a bit prejudicial because she has used the program herself. She learned about how allergies affect her son, who suffers from asthma.

E-doc was cited by *Fortune* magazine as one reason Acxiom was ranked one of the best companies to work for in the country.

Dr. Smith says he has been contacted by other companies — including a couple of nationwide corporations — expressing interest in e-doc. Officials from a university also expressed interest in the program for faculty and employees.

Dr. Smith has taken steps to create a company around the program through the UAMS biomedical business incubator, Arkansas BioVentures, which has a process for moving discoveries through the planning and copyright stages to setting up shop in the incubator. At various points, committees review plans for a prospective company, analyzing elements such as the potential market and operating costs.

When patented, UAMS will own the business and the creator can license it from the university, which is paid with a cut of revenue.

Dr. Smith says he is working with UAMS officials to determine the future of the e-doc program. As it grows, Dr. Smith says, he would need to hire additional physicians to handle the increased e-mail traffic.

"I am absolutely convinced the time is right," he said. ■

Parts of this article reprinted from Aug. 30 issue of Arkansas Business.

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Meet Our Members

Kimberly Ferguson Garner, MD

By JUDITH M. GALLMAN

Dr. Kimberly Ferguson Garner can't stand inefficiency. That's why Dr. Garner, a family practice physician with a solo practice in Pine Bluff, the Garner Family Clinic, has developed a paperless office.

Actually, Dr. Garner can't stop paper from coming into her office, and she must print some prescriptions and a few forms for patients. But she keeps all her records, including patient billing, in electronic form. She's among an estimated 5% of physicians nationwide who have implemented electronic technology in their practices.

She decided before opening her practice to incur the substantial start-up cost of creating an electronic office — about \$100,000 for an integrative computer and billing system (Next Gen, Millbrook and Rosetta interface shell), servers, hubs and personal computers in each examination room — and she made the decision without knowing much about computers.

"I am computer savvy now," said Dr. Garner, 37.

Saving Time

As a resident, Dr. Garner realized a big challenge office staff face is finding a patient's chart, and she noticed unnecessary, frequent repetition of data entry. At the same time, she began to understand the implications computers have on effective management. She also decided medical care likely would become interactive with computers.

"There are better ways to manage information," Dr. Garner said. But physicians are resistant to electronic conversion simply because record management has "always been done on paper. Just because it has been on paper doesn't mean it always has to be that way."

Computers save time that Dr. Garner would rather spend talking to and caring for patients. Besides, physicians and many staff members are too highly trained and paid for repetitive clerical matters associated with keeping records. Furthermore, computers can provide research data and statistics for measuring the effectiveness of common therapies that today's doctors really can't be sure work, she said.

"We have a shrinking amount of money available for health care," Dr. Garner said, zeroing in on the wasteful repetitive tasks.

"We have got to be able to control it.

"The way we [physicians] manage

information, we are far behind [other professions]. We still do so many things inefficiently."

Earlier Career

Dr. Garner is a single mother whose first career was as a registered dietitian. She holds a bachelor's degree in dietetics from Louisiana Tech University in Ruston, La., and worked as a consultant dietitian and nutritionist in Pine Bluff until the resident director of the Area Health Education Center-Pine Bluff office, Dr. Herb Findley, encouraged her to attend medical school. She took the plunge.

She moved to Little Rock to live in a dorm at the University of Arkansas for Medical Sciences.

After six years of being out of school, returning to the classroom was no easy task, but she adjusted, spending all of her time studying. Because she had no premedical courses,

Dr. Garner finds time to manage a practice, be a mom and go to law school.

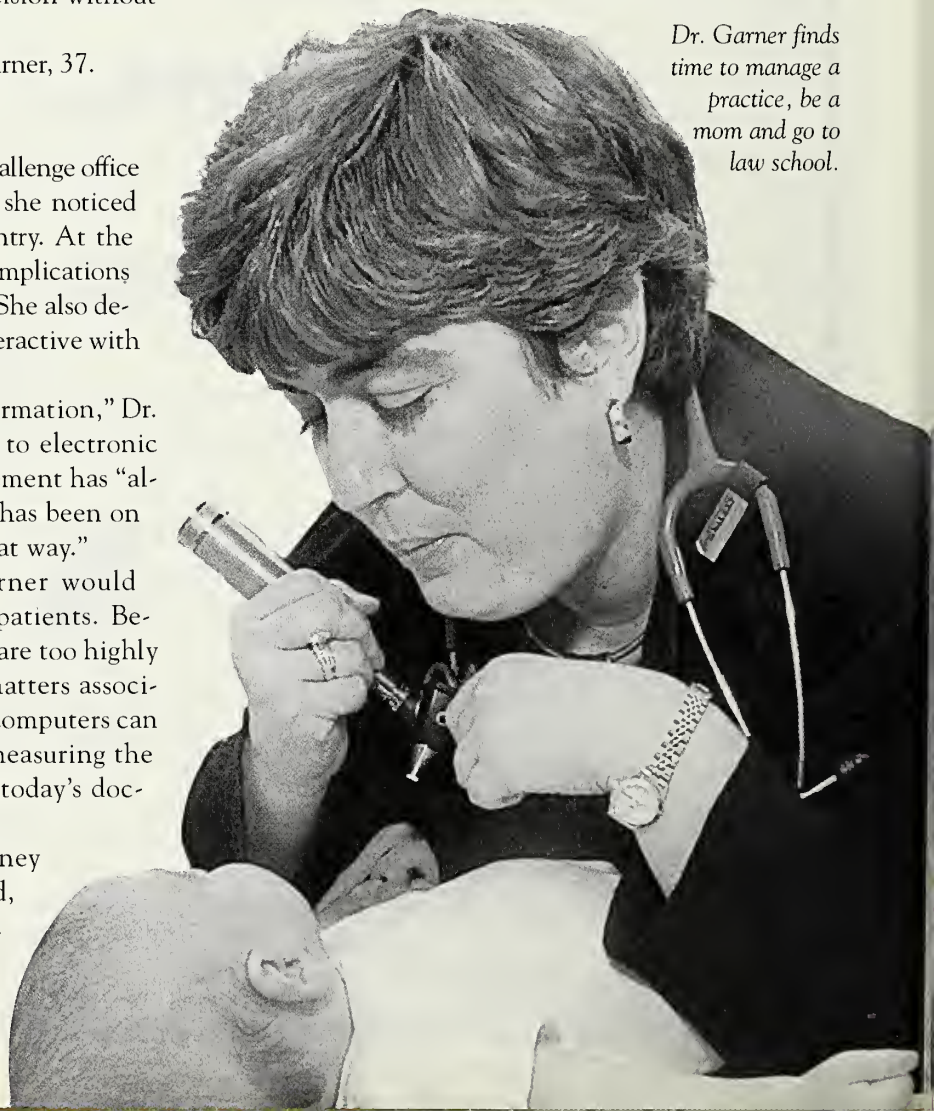


PHOTO: R. J. ORIEZ

she had some catching up to do. But she did have invaluable life experiences.

"I had a lot of motivation. I had quit a job, a good job; I had a child to support," she said. "I didn't have the distractions [others faced]."

While her counterparts were perhaps better prepared educationally, she was a bit ahead when she began her clinical rotations because she had worked in a hospital and had experience charting and writing notes.

There is a strong and obvious connection between nutrition and health, she said.

"Diet therapy is a big part of medical care," she said, estimating the top 10 chronic medical problems — diabetes, heart disease, hypertension, for example — require diet therapy. And as a nutritionist and registered dietitian, she had served in pediatrics, helped teen-agers and adults, and cared for geriatric populations. Family practice medicine was a natural and logical choice, she said.

Dr. Garner received her medical degree in 1994 and performed a family practice residency in the AHEC-Pine Bluff facility. She opened her solo practice in 1997 at the Good Faith Medical Complex. She anticipates moving the practice later this year.

Dr. Garner's daughter, Kelley, 14, who lived with her grandparents while her mom went to med school, is a stu-

dent in nearby Watson Chapel. Dr. Garner manages to find time to be a Volunteer in Public Schools in Pine Bluff.

Law School

It was her strong interest in an electronic office that started Dr. Garner down another path — law school. When she set up her electronic office, she found little legal precedent, case law or history on electronic data management. So set her mind on going to law school to find out for herself.

She started classes at the University of Arkansas at Little Rock School of Law about 18 months ago. She anticipates completing her juris doctorate degree in May 2002.

"I believe somewhere down the road there will be a need for a person who understands the law on computers and medicine," said Dr. Garner, who anticipates assisting with national and local legislation touching on the topics as more hospitals and physicians' offices turn to electronic records management.

That's where her membership in the Arkansas Medical Society will help. A member since 1997, Dr. Garner joined the society to have the opportunity to present a unified position on issues. Through an organization such as the AMS, physicians can better monitor issues that affect health care and health care costs at all levels, she said. ■

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It Keeps Happening!

J. KELLEY AVERY, MD

The history reveals 10 separate surgical procedures ranging from tonsillectomy to three separate procedures for "lysis of adhesions" without evidence of true intestinal obstruction. In all, she had 16 previous admissions for abdominal and back pain.

According to her history, a 38-year-old beautician had a total abdominal hysterectomy with bilateral salpingoophorectomy at age 16 for carcinoma of the cervix. The age at which this was done almost surely is in error, but the record never explores this. She subsequently had two Cesarean sections with the delivery of healthy babies.

The history reveals 10 separate surgical procedures ranging from tonsillectomy to three separate procedures for "lysis of adhesions" without evidence of true intestinal obstruction. In all, she had 16 previous admissions for abdominal and back pain. On one of these occasions, a diagnosis of "mild pancreatitis" was made.

This time she presented to a surgeon for abdominal pain. He stated, "She was very anxious to have surgery." After the examination, he stated, "The potential benefits of the surgery in my estimation are far outweighed by the potential downside." She was not obstructed, and her history made surgery something to be done "if all else fails."

More than a year later she saw the same surgeon with some "knots in the right side of her neck." She correctly recounted her long and complicated medical record, including the multiple operations. She asked to have a serum amylase done, since she had previously had the diagnosis of mild pancreatitis.

The examination revealed slight tenderness over the mastoid process on the right and the small (1 cm) nodes, thought to be three. X-rays of her neck and mastoids were negative and she was given a trial of antibiotics to see if the nodes would respond, but when she returned as directed five days later, the nodes were unchanged. Same-day surgery was scheduled for the next week. The diagnosis was right posterior cervical adenopathy. A biopsy was to be done, and the physician stated in the record, "She has a high-anxiety state, and I think it is understandable."

A standard hospital informed consent form was used, which stated, "I hereby certify that I have read and fully understand the above authorization [right cervical node biopsy] for surgical treatment, the reasons why the above

named surgery is considered necessary, its advantages and the possible complications, if any, as well as possible alternative modes of treatment which were explained to me by my doctor." She signed her name.

Under a general anesthetic, the operative site was prepared and draped in the usual fashion. "We dissected down through the trapezius and identified and protected neural tissue which I presumed was part of the spinal accessory nerve." The rest of the operation was described and the tissue was sent to the pathologist. The nodes were benign and no "neural tissue" was identified.

The patient returned to the physician's office five days later, as instructed, and stated that she had been unable to raise her right arm. Believing that she was not tolerating the post-surgical pain well, her doctor gave her some entericcoated aspirin-like medication for pain, with instructions to return, if necessary, in two weeks.

However, she was admitted the next day to the hospital because of the pain and the persistent inability to raise her arm. She returned to her primary care physician where she had a complete workup for the postoperative complication. The studies were all negative except for the electromyography and nerve conduction study (EMG/NCS), which showed "mild denervation changes in the right lower cervical paraspinal muscles consistent with a right lower cervical radiculopathy."

The examiner stated that she showed "no objective neurologic deficit" at that time. She did not improve, and requested referral to a neurosurgeon of her own choice.

This surgeon reviewed the record of the previous procedure and ordered another EMG/NCS. This study showed "acute and partial denervation of the right spinal accessory nerve."

Pain and disability continued despite physical therapy over a period of months. She required narcotics for pain, and on one of her outpatient visits the examiner stated, "Right sternomastoid is much stronger and nearly equal in strength to left."

After eight months of therapy and repeated examinations, but with no improvement, the patient went across the state on her own to consult yet another physician, a plastic and reconstructive surgeon. She then underwent surgery to repair the right spinal accessory nerve, even after having been told by the surgeon that the operation had no more than a 10% chance of success.

At surgery an effort was made to identify the nerve in question, and it was believed to be encased in scar tissue from the previous surgery. A prominent neurosurgeon was called into the operating room, and he did not think that any nerve tissue was identified. The pathologist, however, stated in his report, "Focally some nerve tissue is seen. The nerve tissue appears slightly degenerated." The patient was left with some permanent disability to the right arm.

A lawsuit was filed charging that the initial surgeon "negligently injured the patient's right spinal accessory nerve while doing a biopsy of nodes in the posterior cervical area. The neurosurgeon first consulted was negligent in not aggressively attempting repair of the nerve after his examination."

After investigation and preparation by both plaintiff and defense, the case was closed by settlement. The medical and legal expense exceeded the damages awarded to this patient.

Loss Prevention Comments

On a previous visit to the surgeon who later did the node biopsy, the patient begged for surgery for her alleged abdominal pain. The surgeon wisely did not recommend surgery. This patient's history would lead the cautious surgeon to defer surgery until absolutely required to manage the presenting problem. The nodes in the right posterior cervical triangle were unimpressive, and there was no response to antibiotic therapy. The surgeon had referred in his record to her high anxiety and nervousness. Reassurance and continued observation for a few weeks would have been in order.

This patient might well have gone to another doctor and, in retrospect, that would have served the surgeon well indeed. The EMG/NCS showed damage to the nerve and she did have some disability in that arm, which coincided with the damage.

The surgical experts criticized the surgeon

for "dissecting through the trapezius" in order to expose the nodes. They contended that the muscle should have been retracted, exposing the posterior cervical triangle. The description of the nerve was less than impressive. His reference to "neural tissue" was interpreted by these physicians as indicating some confusion as to the nature of the tissue he encountered. The pathology report did not reveal any "neural tissue."

The first surgical consultant had evidence that the nerve damage was incomplete, so he did not adopt an aggressive approach to treatment. Rather, he believed that time and physical therapy would bring improvement. It apparently did, according to a later study that stated that the arm was stronger and almost equal to the unaffected side. His decision not to operate was apparently a good one in the eyes of both the experts who reviewed this case and the reviewing surgeons for the defense.

One has only to look at the history of this patient's hospital admissions and surgical procedures to conclude that some psychosomatic forces were at work. She wanted surgery. She told the surgeon so on her first visit to him. Her history warranted at least a consideration of Munchausen's syndrome. Although found liable for damages to this patient, this surgeon cannot be harshly criticized. The patient was not only very convincing to him but had been to others, and continued to be.

Since damage to the spinal accessory nerve is a known and unintended complication of surgery in the posterior cervical triangle, it appears that this patient should have been informed of its danger and it should have been part of the informed consent discussion and documentation. This omission is the reason that this case had to be settled. Had it been there, the lawsuit probably would not have been filed in the first place. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify.

Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the February 1999 issue of Tennessee Medicine. It is reprinted with permission.

The surgical experts criticized the surgeon for "dissecting through the trapezius" in order to expose the nodes. They contended that the muscle should have been retracted, exposing the posterior cervical triangle.



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STATE HEALTH WATCH

Reported Cases of Selected Diseases in Arkansas

Profile for October 1999

The three-month delay in the disease profile for a given month is designed to minimize any changes that may occur because of the effects of late reporting. The numbers in the table reflect the actual disease onset date, if known, rather than the date the disease was reported. ■

Disease Name	Total Reported Cases YTD 1999	Total Reported Cases YTD 1998	Total Reported Cases YTD 1997	Total Reported Cases 1998	Total Reported Cases 1997
Campylobacteriosis	142	159	154	179	175
Giardiasis	129	142	203	168	220
Salmonellosis	593	555	394	616	445
Shigellosis	73	194	230	211	273
Hepatitis A	50	79	194	82	223
Hepatitis B	60	103	81	115	106
Hepatitis C	7	7	5	10	5
Meningococcal Infections	32	27	31	31	38
Viral/Aseptic Meningitis	42	69	24	77	26
Ehrlichiosis	21	14	22	14	22
Lyme Disease	4	8	27	8	27
Rocky Mt. Spotted Fever	18	23	33	23	31
Tularemia	16	25	24	26	24
Measles	4	0	0	0	0
Mumps	0	13	1	13	3
Chlamydia	5,220	3,201	2,470	4,127	2,554
Gonorrhea	2,825	3,281	6,201	3,962	4,388
Syphilis	181	267	355	294	394
Pertussis	19	87	56	93	61
Tuberculosis	141	122	147	171	200

For a complete list of reportable diseases in Arkansas, call the Arkansas Department of Health, Division of Epidemiology at (501)661-2893.

2000 Shuffield Award

The Arkansas Medical Society is seeking nominations for the 2000 Shuffield Award, which will be presented at the annual meeting May 5-6 in Little Rock.

This award is given each year to recognize **laypersons** in Arkansas who have done outstanding community work in the health care field. The individual might be a newspaper reporter, television personality, government official, teacher or individual promoting a community or health-related program. The person **cannot be a physician or a physician's immediate family member**. The nominations may come from a county medical society, AMS or alliance member.

All nominations must be received by Feb. 29, 2000. Past nominees may be renominated. If you know someone worthy of this honor, please contact the AMS office at (501) 224-8967 or (800) 542-1058.



Providing Culturally Sensitive Care to Hispanic Patients in Arkansas

Providing culturally sensitive care to Hispanic patients can lead to a better patient-physician relationship. Greater compliance, improved health care delivery and treatment efficacy also are enhanced when health care providers understand the Hispanic patient's expectation of care and health paradigm.¹ An inability to understand the Hispanic patient's health beliefs, social system and barriers to health care may lead to a communication breakdown and compromise maximal delivery of care.

DEANNA PEREZ WILLIAMS, M.A.
HERBERT A. MCPHERSON JR., MD

The population of Hispanics in Arkansas has increased dramatically in the last decade. Immigration accounts for much of this ethnic group's growth, but data remains limited because of the inability to count immigrants who enter Arkansas each year.² Although the influx of Hispanic patients in Arkansas has increased, health care providers have limited knowledge about their health beliefs, status or behavior.³

Hispanic Health Beliefs

In Arkansas, the majority of Hispanics are of Mexican heritage, but other individuals may be from Guatemala, El Salvador and Honduras, as well. Although use of the ethnic term "Hispanic" assumes homogeneity for populations diverse in culture and heritage, there are some important cultural differences between the various Hispanic ethnic groups. However, they share core beliefs concerning health and illness. Recent Hispanic immigrants are more likely to maintain traditional beliefs and values, whereas U.S. born Hispanics are more likely to have more assimilated attitudes.³

For the Hispanic, the etiology of health and illness is based on the belief that the mind and body are inseparable. That is, there is not a perceived dichotomy between emotional and somatic illness. Instead, the mind and body are connected to the physical, emotional and spiritual self. This cultural con-

struct explains why it is natural for Hispanic patients to present emotional problems as part of their somatic complaint. For example, *los nervios*, "the nerves," can be referred to for almost any physical illness.⁴

An important concept of the Hispanic health belief system is that illness is caused by an imbalance of bodily "humors" or fluids. When the bodily humors are in equilibrium, the body is in a healthy state. A change in the balance can bring about illness. Therefore, for the restoration of health, a balance must be achieved with the natural and supernatural environment. Consequently, the Hispanic will treat these imbalances according to the hot/cold theory, which determines treatment.⁴ Pregnancy, for example, is considered a "hot" state, and therefore hot medicines and hot foods are avoided. Since iron tablets and prenatal vitamins are considered "hot," Hispanic women may avoid taking these. However, they may be encouraged to take these vitamins with a "cold" substance such as fruit juice to minimize the vitamin's hot effects.⁵

Self-Care

Self-care is a central concept in the Hispanic health belief system. It is defined as self-assessment, self-diagnosis and self-treatment both to maintain health and treat illness. Activities performed by an individual, family or community to achieve, main-





tain or promote optimal health is considered self-care.⁶

An estimated 70% to 90% of self-recognized episodes of illness within the Hispanic culture are managed outside the professional health care system.¹ Since self-care is incorporated into the Hispanic belief system of health, home remedies are usually tried first for illnesses within the family network according to the hot/cold theory. Many of the home remedies consist of herbal remedies, herbal teas or foods. Nightshade (yerba mora), for example, is used to relieve colic, diarrhea and menstrual cramps. Consequently, seeking medical treatment is delayed.^{3,5,7}

Self-care also is largely attributed to the rationale in the decision-making process of when to seek medical prenatal care. The pregnant Hispanic woman may resort to the cultural practices of her health belief system that prescribe prenatal care treatment and behavior during pregnancy. Since she believes these cultural practices will protect herself and her fetus' health, she does not perceive a need to seek early medical prenatal care.^{5,7}

The Family

Decisions about health are not left to the ill individual but rather the family network or extended family. Consequently, the family network is the most important source of self-care information and emotional and physical support during illness. Family decisions may even supersede decisions made by health care providers. However, compared to other groups, Hispanics encourage positive health behaviors, which contribute to more favorable health outcomes.^{3,7}

Barriers to Health Care

In Arkansas, lack of financial resources force many Hispanics to forgo any type of contact with the health care delivery system. Many Hispanics are often in low-wage positions without the choice or ability to afford health insurance.² A 1998 survey by the Council of Economic Advisors indicates that Hispanics in the United States are the least likely group to be insured as compared to others.⁸ Many Hispanics in Arkansas lack a basic knowledge regarding available medical resources. There also are other factors contributing to their vulnerability including the language barrier, inadequate transportation and acculturation stresses. As a result, this population tends to be medically underserved and often neglected.²

Culturally Sensitive Care

Providing culturally sensitive care begins with establishing a rapport with Hispanic patients through personal conversation to determine their perception of illness. They value *simpatia*, which refers to a desire for warm interpersonal relations. Physicians who use *simpatia* will be polite, respectful and will avoid criticism, confrontation or assertiveness.⁹

By being culturally aware and showing concern, the patient will be more receptive to care and treatment. Here are some further suggestions for providing culturally sensitive care to Hispanic patients:

1. Establish rapport with small talk. Begin communicating with the Hispanic patient with small talk, which will contribute to establishing trust. Starting the interaction with questions about their illness may be interpreted as being indifferent or uncaring.

2. Ask open-ended questions. Refrain from asking "yes" or "no" questions. Hispanic patients may respond to questions with a "yes" as an act of courtesy, which may not necessarily mean they agree or understand.

3. Acknowledge family. Include family members in the decision-making process whenever possible, particularly a Hispanic woman's spouse. Ask if patients need to consult with their family about major decisions. Respect family roles. For example, a Hispanic woman may prefer her mother or other female family member in the labor room instead of her spouse.

4. Acknowledge their health belief system. Being sensitive to their beliefs, practices and rituals also will enhance rapport. Incorporating their cultural beliefs into treatment strategies will ensure that treatment will be effective. Listen to how Hispanic patients perceive symptoms and treatment management. Importantly, inquire if they have self-treated with any of their home remedies.

5. Acknowledge their modesty. Modesty is a major issue during examination for females especially if the physician is a male. For example,

women from the rural areas of Mexico are used to having a lay midwife as a birth attendant during pregnancy. It is important to try to prevent embarrassment as much as possible during any examination.

6. Use an interpreter. When possible use an interpreter especially to explain complex medical information. If an interpreter is unavailable use simple language, and avoid technical and medical terms. Refrain from using a male family member to interpret for a female family member because of modesty.

7. Communicate in Spanish. Consider learning a few greetings in Spanish. This will go a long way in establishing rapport. There are several medical phrase books in Spanish available.^{5,10}

Conclusion

Contrary to popular belief, most immigrants who arrive in the United States are in better health than their U.S. born counterparts. However, their health deteriorates in direct proportion to their stay. Relocation, living in poverty, coping with language barriers and other social stresses, as well as adopting American high-risk health behaviors, contribute to their poor health status.¹¹

Understanding the Hispanic patient's perceptions of health and illness, acknowledging the importance of the family and establishing a rapport may increase the likelihood that patients are given information most appropriate to their illness. By avoiding cultural imposition, or the expectation that everyone should conform to the culture of the majority, the patient's chance for a successful outcome increases. Perhaps one of the most important challenges to physicians and other health care providers in the next millennium is providing culturally diverse health care to the growing multicultural populations in Arkansas. The implications for providing culturally competent care for all vulnerable populations will contribute to improving the state's health ranking, which is currently at 48th nationally.¹² ■

References

1. Germain, C. P. (1992). Cultural care: A bridge between sickness, illness and disease. *Holistic Nursing Practice*, 6, (3), 1-9.
2. Mercy Health Center. (1998). Diabetes Initiative Grant Proposal. Mercy Health Center: Bentonville, Ark.
3. Gordon, S. M. (1994). Hispanic cultural health beliefs and folk remedies. *Journal of Holistic Nursing*, 12 (3), 307-322.
4. Maduro, R. (1983). Curanderismo and Latino views of disease and curing. *The Western Journal of Medicine*, 139, 868-874.
5. DePacheco, M. R. & Hutti, M. H. (1998). Cultural beliefs and health care practices of childbearing Puerto Rican American women and Mexican American women: A review of the literature. *Mother Baby Journal* 3, (1), 14-25.
6. Hill, L. & Smith, N. (1990). *Self-Care Nursing: Promotion of Health*. Norwalk, Connecticut: Appleton & Lange.
7. Albrecht, S. L. & Miller, M. K. (1995). Hispanic group differences in prenatal care. *Social Biology*, 43 (1-2), 38-58.
8. Council of Economic Advisers. (September, 1998). *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin*. <http://www.whitehouse.gov/WH/EOP/CEA/html/publications.html>.
9. Marin, G. AIDS prevention among Hispanics: Needs, Risk Behaviors, and Cultural Values. *Public Health Reports*, 104 (5), 411-415.
10. Byrd, T.L., Mullen, P. D., & Selwyn, B.J. (1996). Initiation of prenatal care by low income Hispanic women in Houston. *Public Health Reports*, 111, 536-540.
11. Kielich, A. M. & Miller, L. (1996). Cultural aspects of women's health care. *Patient Care*, 30 (16), 60-76.
12. Reliastar. (1998). *The Reliastar State Health Rankings. An analysis of the relative healthiness of the populations in all 50 states*. Arundel Street Consulting, Inc., St. Paul, Minn.

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CARDIOLOGY



The Waves of the Electrocardiogram: Part 4: The T Wave

LEE DAVIS, MD — JOE K. BISSETT, MD — J. DAVID TALLEY, MD

This is the fourth article in a series of discussions reviewing the principle features involved in interpreting electrocardiograms (ECGs). In this article we will discuss the T wave and its variations.

Patient Presentation

A 65-year-old African-American male presented to the hospital with shortness of air, general malaise, fatigue, anorexia, nocturia and pruritus.

He had an S3 gallop, lower extremity edema, bibasilar crackles and pedal edema. ECG showed normal sinus rhythm, left ventricular hypertrophy and tall, peaked T waves (Fig. 1). Electrolytes obtained revealed potassium of 6.2 mEq/L and creatinine of 6.9 mg/dl.

The T wave

Ventricular repolarization. The

heart produces and transmits electrical current. With the use of an amplifier, electrical currents can be recorded throughout the body. Electrocardiograms record the changes in electrical current throughout the cardiac cycle. These changes are recorded as the p wave, QRS complex and T wave. The T wave represents ventricular repolarization and usually lasts 0.16 second.

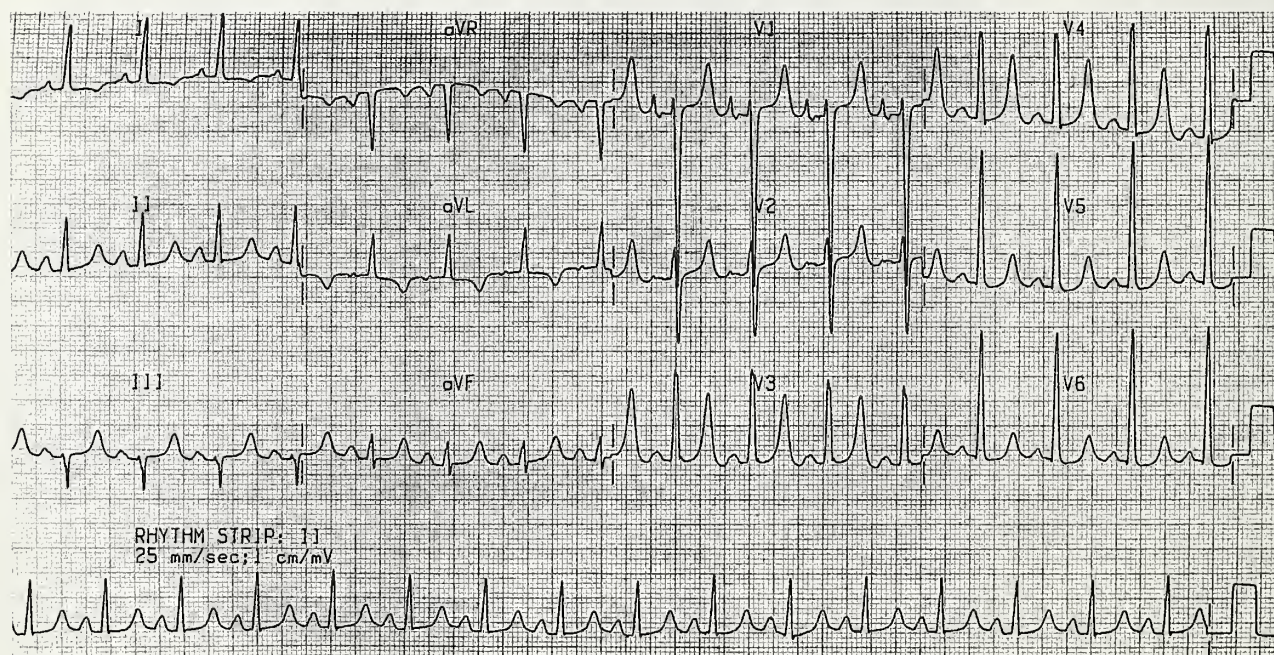


Fig. 1: ECG showed normal sinus rhythm, left ventricular hypertrophy and tall, peaked T waves (seen especially in V₃ and V₄) consistent with hyperkalemia. The serum potassium was 6.2 mEq/L.

Table 1. Examples of primary and secondary T wave abnormalities

Primary T wave Abnormalities

Constrictive pericarditis
Hypertrophic cardiomyopathy
Pericarditis
Myocarditis
Post-tachycardic state
Myocardial contusion
Myocardial ischemia
Pheochromocytoma
Hyperventilation
Digitalis

Secondary T wave abnormalities

Left ventricular hemorrhage
Bundle branch block

T wave Axis. The T wave vector is leftward, inferior and anterior in most adults. Invariably, T waves are upright in leads I and II and inverted in A_{VR} . T waves in lead I are inverted in about 50% of females and uncommon in males. In a study by Lamb, approximately 1% of men had inverted T wave in lead I.^{1,2} The presence of T wave inversion in two or more right precordial leads in a normal adult is called persistent juvenile pattern.

T wave Amplitude. The T waves amplitude should be less than 6mm in all the limb leads. The tallest T waves are present in precordial leads. The amplitude in precordial leads range from 6mm to 12mm. Amplitude significantly decreases in males over the age of 40 and is decreased in the left precordial leads.¹ T waves should be no less than 10% of the height of the of the R wave in any lead.³

T wave Shape. T waves are usually asymmetrical. In patients greater than 30 years of age, inverted T waves in V2 and V3 may be normal. Inverted T waves in lead V1 are normal. T waves normally have an upward concavity if the T wave is upright and downward concavity if the T wave is inverted.⁴

T wave Changes. T wave changes

are a vast topic. These changes are sometime referred to as nonspecific due to the large differential in reference to these changes (See Table 1). T wave changes may be due to local or global abnormalities in ventricular repolarization. Primary T wave abnormalities are the result of regional alteration in the duration of depolarized state, such as ischemia. Secondary T wave changes are due to an alteration in the timing and sequencing of the ventricular repolarization.

T wave changes are more specific when clinical information is correlated with ECG findings. For example, the T wave changes noted in the case presentation were due to hyperkalemia. T waves are tall, peaked and narrow in precordial leads. There are a plethora of additional causes of tall T waves. If the case presentation was to feature an individual with chest pain, the ECG could have represented the hyperacute T waves of acute myocardial infarction. ■

References

1. Hiss RG, Lamb LE, Allen MF. Electrocardiographic findings in 67,375 asymptomatic patients. *Am J Cardiol* 1960;6:200.
2. Lamb LE. *Electrocardiography and Vectorcardiography*. Philadelphia, WB Saunders, 1965.
3. Lepeschkin E. Duration of electrocardiographic deflection and intervals: Man. In Atلمان PE, Dittmer DS (eds), *Respiration and Circulation*. Chapter VI. Bethesda Federation of American Societies for Experimental Biology, 1971, 277.
4. Green LS, Lux RL, Haws CW, et al. Effects of age, sex and body habitus on QRS and ST-T potential maps of 1100 normal subjects. *Circulation* 1985;71:244.

Drs. Davis, Bissett and Talley are from the department of internal medicine, division of cardiology, UAMS Medical Center and John L. McCellan Memorial Veterans Hospital in Little Rock.

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CALENDAR

AMS/AHA Coding Workshops

Karen Scott, a certified professional coder from the American Association of Professional Coders, will conduct several daylong workshops across the state on intermediate CPT coding. The workshop is sponsored by the Arkansas Medical Society and the Arkansas Hospital Association. Registration is \$125 for AMS members and staff and \$175 for others. To learn more about the seminars, call Donna Boroughs, Arkansas Hospital Association, (501) 224-7878.

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Feb. 16

Intermediate ICD-9 Coding Workshop
Pine Bluff

April 11

Advanced ICD-9 Coding Workshop
Camden

April 12

Advanced ICD-9 Coding Workshop
Pine Bluff

March 25-28

National Leadership Development Conference

"Is It Good Medicine? A Call to Lead: A Challenge to Serve" is the topic of the National Leadership Development Conference March 25-28 at the Fontainebleau Hilton Hotel in Miami Beach, Fla. The keynote speaker is Tom Peters, acclaimed author of "In Search of Excellence" and "The Circle of Innovation." To register for the NLDC and for additional information, call the American Medical Association's registration hot line, (800) 262-3211, or visit the NLDC web site, www.ama-assn.org. To reserve a hotel room, call (800) 548-8886 or (305) 538-2000, or visit the hotel web site, www.hilton.com.

May 4-5

Antimicrobial Resistance

The Royal Society of Medicine Foundation, Illinois, and the Royal Society of Medicine, London, have planned a two-day international conference on antimicro-

bial resistance in Washington, D.C. For more information, contact the Royal Society of Medicine Foundation, (847) 234-6382, fax (847) 234-6511 or e-mail rsmfil@aol.com.

May 12-19

American Occupational Health Conference

The American Occupational Health Conference is set for May 12-19 at the Pennsylvania Convention Center in Philadelphia. J.D. Kleinke, MSB, medical economist and author, and W. Allen Schaffer, MD, senior vice president and chief medical officer of CIGNA HealthCare, are the keynote speakers. The conference serves as the annual meeting for the American College of Occupational and Environmental Medicine and the American Association of Occupational Health Nurses Inc. For more information, contact Debra Bethard-Caplick at ACOEM, (847) 818-1800, ext. 383, or e-mail dcaplick@acoem.org; or contact Yvonne B. Matherne, AAOHN, (770) 455-7757, ext. 110, or e-mail yvonne@aaohn.org.

455-7757, ext. 110, or e-mail yvonne@aaohn.org.

June 8-10

American Board of Medical Specialties Conference

"Credentialing Physician Specialists: A World Perspective" will be held June 8-10 at the Westin Hotel River North in Chicago. The conference is sponsored by the American Board of Specialties' Research and Education Foundation and the Royal College of Physicians and Surgeons of Canada. Registration fees are \$485, and May 5 is the reservation deadline. For more information about the conference, call the ABMS, (847) 491-9091. To reserve directly with the hotel, call (312) 744-1990.

July 7

The Royal Society of Medicine

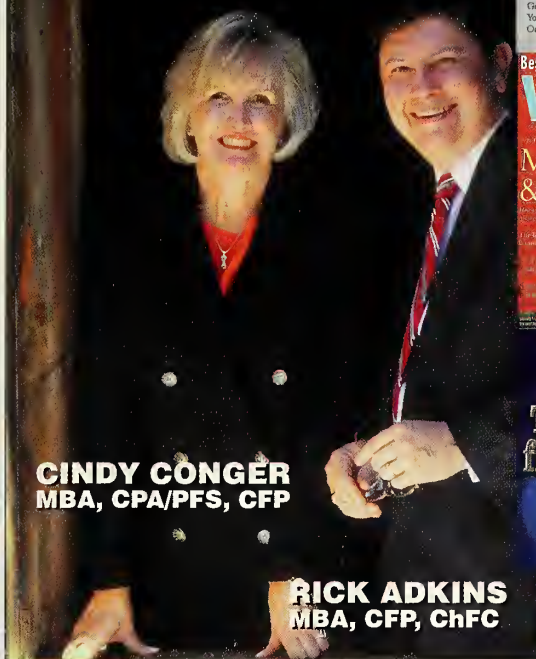
Fellows and members can join the Royal Society of Medicine for Millennium Member's Day on July 2 in London. The RSM has millennium activities — library competition, library events, oral presentations, sporting events, social events and products — throughout the year. If you're interested in more details about RSM millennium events, contact Kate Lindley, 0171 290 3947 or 020 7290 3947. Keep up to date by visiting the web site at www.royalocmed.ac.uk/2000.htm.

May 5-6, 2000 Arkansas Medical Society Annual Meeting

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A Special Thank You

to the following members who are participating in the Arkansas Medical Society's long-range planning project. These members have volunteered their time to discuss problems and challenges they encounter and how the AMS can help meet the needs of Arkansas' physicians.

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PEOPLE+EVENTS

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Little Rock Doctor Noted for Care

The Provider Recognition Program of the American Diabetes Association and the National Committee for Quality Assurance recently honored **Dr. William H. Riley Jr.** of Little Rock with its Recognition status.

Dr. Riley earned the status, which he will hold for three years, by meeting standards of care for his diabetes patients, including eye exams, blood pressure tests and nutrition therapy. He also has earned a high level of patient satisfaction.

A graduate of the University of Arkansas for Medical Sciences, Dr. Riley has been treating diabetes patients for 39 years. He practices at St. Vincent Family Clinic.

"In this era of cost-consciousness, it is important to recognize physicians like Dr. Riley who are providing quality care for their patients with diabetes," said Dr. Bruce Zimmerman, ADA president.

Green Forest Doctor Hits 30-Year Mark

Dr. Oliver Wallace of Green Forest recently was honored for 30 years of service as a member of the Carroll Regional Medical Center staff. Dr. Wallace was treated to a breakfast reception and honored with a pair of suspenders embroidered with the CRMC logo.

Dr. Strode to Lead AAFP Commission

Dr. Steven W. Strode of Little Rock recently was elected chairman of the American Academy of Family Physicians Commission on Continuing Medical Education.

Dr. Strode, who has served on the commission for five years, also was honored by AAFP for excellence in education. He received a set of marble bookends at the AAFP's annual assembly.

Physicians Receive Awards From AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

AMA recipients for October include **Dr. Debra Lynn Simmons** of Little Rock and **Dr. James Randall Thrasher** of Strawberry.

OBITUARIES

William Clark Cheek, MD

Dr. Cheek, 33, of Fayetteville died Nov. 11, 1999.

Dr. Cheek was a radiologist with Northwest Arkansas Radiology Associates in Fayetteville and also had practiced with Muskogee Radiological Group in Muskogee, Okla. He was a graduate of the University of Oklahoma College of

Medicine and Northeastern State University in Tahlequah, Okla. He completed his residency at Health Sciences Center in Oklahoma City.

He is survived by his wife, Kelly Deann, and two children.

Donald L. Toon, MD

Dr. Toon, 67, of Crossett died Nov. 16, 1999.

Dr. Toon completed a rotating internship at Baptist Medical Center in Little Rock and began his practice in Crossett in 1966. He served two years in the U.S. Army and earned bachelor of science degrees in agriculture and medicine. He received his medical degree from the University of Arkansas School of Medicine in 1965.

Dr. Toon served on numerous boards and committees in Crossett and Ashley County.

He is survived by his wife, Nancy, two sons and three grandchildren.

Walter J. Wilkins Jr., MD

Dr. Wilkins, 80, of Pine Bluff died Oct. 9, 1999.

Dr. Wilkins was a general surgeon in Pine Bluff from 1951 until his retirement in 1986. He served in the Army Medical Corps from 1945-47 and completed his surgical residency training at Presbyterian-St. Luke's Hospital and Cook County Hospital in Chicago. He completed an internship and

residency at Jefferson Hospital in Roanoke, Va., from 1944-45 and 1948. He graduated from Washington and Lee University in Lexington, Va., in 1941 and received his medical degree from Johns Hopkins University Medical School in Baltimore in 1944.

Dr. Wilkins, who was very socially and civically active in Pine Bluff, was chief of surgery at Jefferson Hospital and Jefferson Regional Medical Center several times.

He is survived by his wife, Genevieve, a son, two daughters and four grandchildren.

Aubrey M. Worrell Jr., MD

Dr. Worrell Jr., 63, of Pine Bluff died Nov. 7, 1999.

Dr. Worrell began his practice in Pine Bluff as an allergist and immunologist, and expanded into environmental medicine in 1980 and nutritional biochemistry in 1984. He earned a bachelor's degree from Ouachita Baptist University in 1958 and a medical degree from the University of Arkansas School of Medicine in 1962. He served as a medical officer in the U.S. Air Force from 1963-73 and retired as a lieutenant colonel. He was active in community affairs and medical societies.

He is survived by his wife, Pamela, two daughters and three granddaughters. ■

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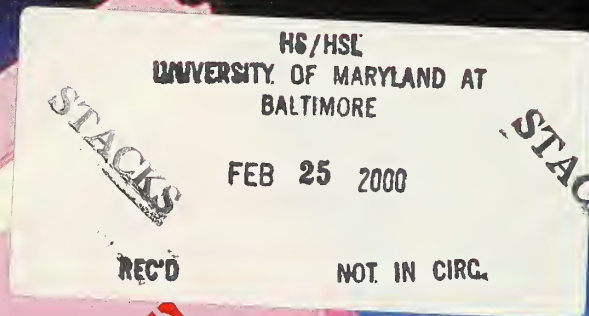
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Vol. 96 No. 9

February 2000

Special Report: Prompt Payment

AMS Backs Effort
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From Insurers



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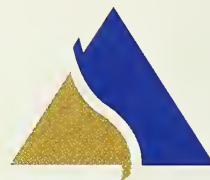
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Traditionally, stellate ganglion blockade has been used for the diagnosis and treatment of upper extremity sympathetic pain. However, this treatment has not been shown to provide adequate sympathetic blockade of the upper extremities. A study demonstrates that a carefully performed upper thoracic sympathetic block with imaging guidance can result in a successful sympathetic blockade of the upper extremities.

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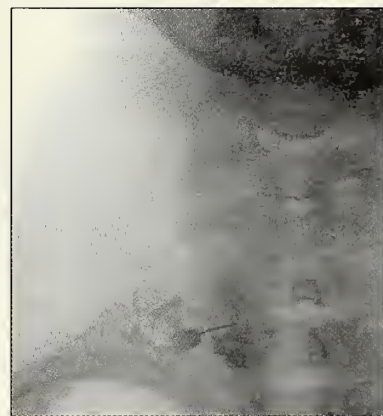
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Snapshot imaging has given MRCP an increasing importance in pancreatic and biliary evaluation.
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A study shows that a stellate ganglion block should include criteria besides Horner's syndrome.
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Doing Our Part

JOHN R. WILLIAMS, MD

I can remember when I did not know what a CT scan or a T cell was, and I have a recollection of that part of the Code of Ethics that regulated the size of the letters on the sign outside my office and prohibited illumination. I cannot even remember how that was enforced, but the emergence or advent of marketing technologies (billboards, Internet, etc.) can't change the simple fact that medicine has and always should deliver, to one individual at a time, care and comfort — physical, emotional, mental and spiritual.

If there ever was a time for unity and good ethics it is now. I am not a good planner, but using whatever talents I have, I am going to be an Arkansas Medical Society advocate. I have neglected my responsibility far too long. I am going to encourage all physicians — majority, minority or otherwise — to embrace perhaps the last possible means to intervene in what appears to be a spiraling decay of some admirable ethics.

I have spent most of my life (nearly 68 years of it) thinking that the bad things that happen are for the most part bad luck. I now realize that most things, good and bad, are the result of planning. I must and did confess in the Arkansas Medical Society's long-range planning session that I have allowed others to do the vast majority of planning and, for the most part, they have done well.

I also confessed to the committee that I had been a member of the Society since 1959 and that this meeting was the first I recalled attending. Oh, I have in 40 years of wearing that caduceus, on my collar or wherever, attended many other meetings and given lots of lip service to organized medicine (whatever that is or has been).

I can tell you now that apathy and a lapse of ethics in favor of "what's right for me today" has been responsible for our present dilemma. It is not the advances in technology, it is not HMOs, PPOs, PCOs (or whatever title may be appropriate).

I am bored with the statement that there is nothing we can do about anything. Well, if we don't do anything, others will. They're doing it right now, inevitably for the patients, good or bad. We need to get one leg up and maybe we can get both legs up for the ride.

Thank you for the opportunity to serve.

Dr. Williams is a family practice physician from Huntsville.

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Insurance Commissioner Creates Program to Deal With Late Payment Concerns

By Z. LYNN ZENO

In response to the concerns of Arkansas physicians and legislators, Mike Pickens, Arkansas Department of Insurance commissioner, has formed the Health Insurance Claim Coordination and Resolution Committee. The committee is a result of the problems between providers and insurers regarding slow payment of claims and balanced billing of patients.

The primary purpose of the HICCRC is to establish a forum whereby health care providers and health insurers may resolve specific slow-pay disputes, exchange information and ideas, and find specific ways to improve communication and expedite the payment of health insurance claims, particularly clean claims.

The role of the department is to mediate where necessary and appropriate, and help resolve complaints. The mediation committee members are:

- David Wroten, assistant executive vice president of the Arkansas Medical Society, who represents providers;
- Kila Hau, executive director of United HealthCare and a representative of insurers;
- Jay Morgan, general counsel for the department of insurance.

The committee will serve as a last resort for providers who have used due diligence to work with insurance carriers.

The HICCRC will draft regulations regarding the process of bringing complaints before the committee. It should be noted that this is an informal and voluntary process. At the initial meeting Dec. 20, Pickens stressed two very important points:

- The department would take an "unfavorable look" at any insurance company that did not approach this process with a spirit of cooperation;
- Neither insurers nor providers may terminate their provider agreement or take any retaliatory action against one another for participation on this committee.

The HICCRC will not referee every specific provider complaint. It will be a committee of last resort for those providers who have used due diligence in working with carriers. Those appearing before the mediation committee must provide specific documentation on dollars involved, patterns of delayed payment and efforts made to remedy the problem.

The process will be limited to the problem participants and will not be a public hearing whereby competitors can observe the airing of another insurance company's dirty laundry. The insurance department will, however, prepare bulletins regarding specific findings or fixes that might be beneficial to providers and carriers experiencing similar problems.

The commissioner has stated firmly that, "regardless of the circumstances, the department would continue to take strong action against those companies and providers who balance-bill patients in violation of their contractual provisions."

AMS members will be apprised of how to contact the HICCRC when the specifics become available. ■

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LEE COUNTY COOPERATIVE CLINIC

Doctors' Complaints Help

By Natalie Gardner

Arkansas doctors are banning to help draft a regulation that would require health maintenance organizations and insurance carriers to process health care claims within 45 calendar days after receipt of a claim.

The proposed regulation would be administered by the Arkansas Department of Insurance. If additional information from a claimant is needed to process a claim, a carrier must notify a provider within 10 days of receipt of the claim. Once that information is received by the carrier, it has an additional 45 days to pay.

The proposed regulation gives the insurance department and its commissioner, Mike Pickens, more authority over carriers and late claims. The insurance department already has the authority to financially penalize any carrier that is consistently delaying payment to providers. In the proposed regulation, there are no penalties for violating the prompt payment time period. Fines will be given only to those companies exhibiting a pattern of delayed payments.

Many physicians across the state have complained of claims being paid 90 to 120 days late, and some as late as 150 days. Many of these claims are clean and complete, and require no additional information to process. They are received by the carrier within 30 working days after the date of service. In the proposed regulation, clean claims must be processed within 30 calendar days.

In a survey by the Arkansas Medical Society in early 1999, central Arkansas physicians ranked American HealthCare Providers, United Healthcare, QualChoice and HealthSource/CIGNA as the worst carriers when it came to prompt payment. The average turnaround time from date filed for clean claims was 77.6 days for American HealthCare Providers, 61.9 for United Healthcare and 49.4 for QualChoice HMO.

"We've been seeing exactly what the AMS survey showed in terms of the slow-pay carriers," said Dr. James Bryan, a family practitioner in sports medicine with Arkansas Sports Medicine and Orthopedic Center. "We've got a large number of claims that are 90 to 120 days out, and some 121 to 150 days out. All this has required us to hire a new employee to work those claims."

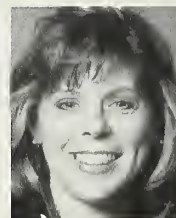
And that goes straight to Dr. Bryan's bottom line.

"There's just no explanation," he said. "And these are clean claims. It just makes things really tough. We generate a large amount of revenue per provider, and we're now not meeting our cash flow because payment is late."

Hitting Home

Rep. Mary Beth Green, R-Van Buren, is sponsor of HB 2098 of 1999, a bill requesting that health carriers in the state make prompt payment for all covered services. The insurance department is working on refining its regulations to comply with the intent of Rep. Green's bill, which was passed by the House of Representatives but was not considered by the Senate.

Rep. Green was eager to sponsor the bill after hearing



Green

Large Insurance Regulation

about several slow-pay problems in Van Buren.

"I was hearing about outstanding payments 90 to 120 days out," she said. "If they're clean claims, there's no reason this should be happening. Insurance companies owe it to us, as consumers, to pay our health care professionals. For smaller health care folks, this really hurts."

Dr. Bradley Mayfield, a surgeon at Ozark General Surgery, P.A., in Mountain View, is one of those small providers hit hard when payments are late.

"This is a new thing to me," he said. "I started my practice in May of last year. Before that I was in a large practice in Tulsa where they did the billing and collections. I wasn't familiar with the process; I expected some delays, but not 90, 120 days or longer."

After the fifth and sixth month of delayed payments, Dr. Mayfield made a call to the insurance department. Although the department has little authority over conflicts between carriers and providers, Pickens and his staff took measures to help resolve Dr. Mayfield's problem.

Like many physicians, Dr. Mayfield believes the best way to handle the problem of slow pay is to work problems out among the providers and the insurers.

"There's a lot of finger-pointing going on, but both sides have some give and take that can be done," he said.

AMS staff members say the best way for physicians to resolve this issue is to stay involved and make consistent contact with their state representatives.


"After you get past the emotional part of this problem, you can begin to look for an answer," Dr. Mayfield said. "It's important to get involved in political aspects of this, writing your legislator. Your voice is being heard somewhere."

The Affect on Patients

At a Dec. 16 hearing of the Legislature's Joint Performance Review Committee, one of the issues discussed was balance-billing patients. Complaints have been filed with the department of insurance accusing providers of billing patients after not getting payment from insurers. According to regulations set by the department of insurance, providers cannot bill patients for the insurers' part.

"We do not bill patients; we take the loss on that," Dr. Mayfield said. "They've paid for that in their premiums. When you start doing that, you're asking to lose patients. The patient has no fault in that."

But Dr. Mayfield agrees it may be helpful for patients to know that their insurance carrier is not paying their claims in a timely manner.



**PAYMENT
DUE**

Dr. Bryan's office sends letters outlining past-due bills to patients after six months. "Patients are getting really upset about this," he said. "The patient gets confused about what their out-of-pocket expenses are. Often, that letter is the first time they realize there's a problem."

The Bottom Line

As far as penalties go, opinions vary across the board. Rep. Green, many physicians and others look at the penalties as a needed part of the regulation.

"If a carrier is consistently late on payments, it should be fined," Rep. Green said. "I pay late fees when my payments on bills are late; they should, too."

The current law allows the Arkansas Department of Insurance to fine companies that have consistently paid claims late.

At a Dec. 16 hearing of the Joint Performance Review Committee, Pickens said he was not opposed to fines, but recognized slow-pay problems often are caused by both providers and insurance carriers.

"I do believe there's a slow-pay problem but not because of an inadequacy in the law and enforcement," Pickens said.

For both parties, there often are problems of incomplete, inadequate and fraudulent bills. Also, providers and carriers sometimes use inefficient computer systems to do their billing. And the fragile financial condition of many insurance companies plays an important factor in slow-pay problems, Pickens said.

"Our department has a financial division where we monitor situations and provide these companies with our expertise," he said. "They just often have cash-flow concerns."

In a recent letter to the Arkansas Medical Society, Pickens wrote: "It is both unrealistic and totally unreasonable to expect that this department or any state agency can or should monitor and police on an individual basis the hundreds of thousands of claims transactions that occur each day. No business requires or wants this level of governmental interference in the daily operations of its business."

Handling Complaints

Another issue in the slow-pay problem is the department of insurance's role in handling complaints from providers. Currently, the department "polices" contracts between insurance carriers and consumers, not providers.

"I want to see the insurance department begin to take complaints from health care providers," Rep. Green said. "If that doesn't work, the Legislature will have to get involved."

Phil Matthews, executive vice president of the Arkansas Hospital Association, asked for an official standing

with the department at the recent hearing.

"We think providers should have standing with the department," he said. "When private carriers are late [on payments] that just makes things worse."

Many hospitals are in fragile financial states because of drastic cuts in Medicare payments from the Balanced Budget Act of 1997.

Pickens wrote, in a recent letter to the AMS, that the department of insurance "cannot and will not formally accept complaints from managed care providers [health care providers]. We will continue to try to mediate any and all possible billing disputes between providers and insurers, which directly impact our constituents, insurance consumers. The statutory mission and responsibility of this agency is consumer protection through insurer solvency and market conduct regulation. The state cannot and should not act as a private collection agency for any profession, including medical care providers."

To help work out some of the disagreements between providers and

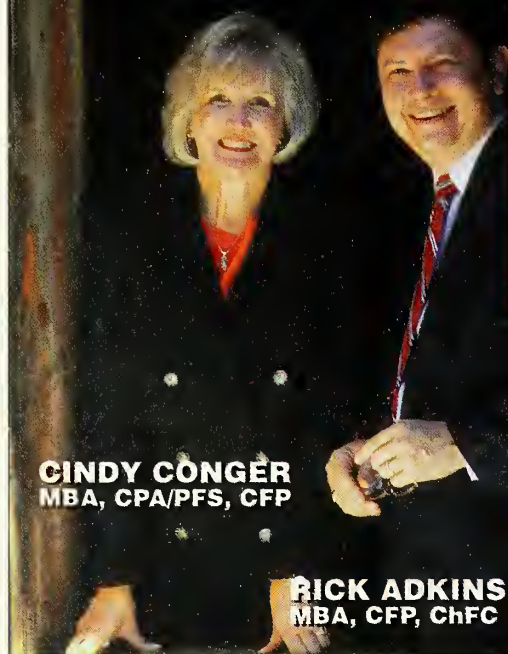
insurance carriers, the department of insurance organized the Health Insurance Claim Coordination and Resolution Committee, made up of representatives from both parties. The committee's primary purpose is to establish a forum where health care providers and insurers can resolve specific slow-pay disputes, exchange information and ideas, and develop specific ways to expedite the payment of claims, particularly clean claims.

The committee's three members are David Wroten, assistant executive vice president of the Arkansas Medical Society; Kila Hau, executive director of United HealthCare, and Jay Morgan, general counsel for the department of insurance. The committee will serve as a last resort for providers who have used due diligence to work with insurance carriers.

In 1999, at least 24 states introduced bills regulating prompt payment of claims. Laws were passed in Virginia, Georgia, Colorado, Texas, Minnesota, Florida, Louisiana, North Carolina and Pennsylvania, among others. ■

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Meet Our Members

Alan Wilson, MD

BY ERICA MARSHALL

Dr. Alan K. Wilson — the only general surgeon in Ashley County — finds that his membership in the Arkansas Medical Society plays a key role in the day-to-day operation of his practice.

"It is especially hard being from out of state and not knowing anyone in the area," Dr. Wilson said. "Going to the Medical Society functions gives me a base of physicians that I can refer my patients to, especially the ones in the area."

Dr. Wilson is chief of medical staff and chief of surgery at Ashley County Medical Center and general surgeon at Surgical Associates of Crossett. After serving his residency in Galveston, Texas, he worked for a multispecialty practice.

"There, all the paper work is done for you," Dr. Wilson said. "When I started my own practice, I had to build it myself from the ground up. The Medical Society has taught me everything I need to know about running my own practice."

Dr. Wilson, born in Los Angeles, was prompted to move to Crossett by Wes Sutton, a recruiter with Medicus Resource Group in Little Rock. Dr. Wilson says he moved to Arkansas in 1997 because he wanted a change in environment and a solo practice in a small town.

"I wanted to live in or around Texas, and since Crossett is close to Texas and a good place to live, we decided to move here," Dr. Wilson said. "Plus, they were finishing the new Ashley County Medical Center, which is a nice facility."

"I am always on

call, but there is no guarantee that I will be called in. Our office is in the hospital, so I don't have to brave the elements when I'm going from seeing a patient to do rounds or a case."

With a chiefly referral practice, Dr. Wilson says the AMS has proved to be a strong resource — Society members have referred their patients to him.

From billing and Medicare to what the Arkansas Legislature is doing in session, Dr. Wilson said the AMS provides him with a great deal of information and keeps him abreast of the issues that need to be addressed by the members of the Society.

"I get more information when the Legislature is in session and updates for any upcoming programs," Dr. Wilson said.

In addition to his AMS involvement, Dr. Wilson is involved in the American Medical Association, the Ashley County Medical Society, the Southern Medical Association and the Texas Medical Association.

In his spare time, Dr. Wilson enjoys ham radio, computers, electronics and fishing and is preparing to take his final flying test for his pilot's license.

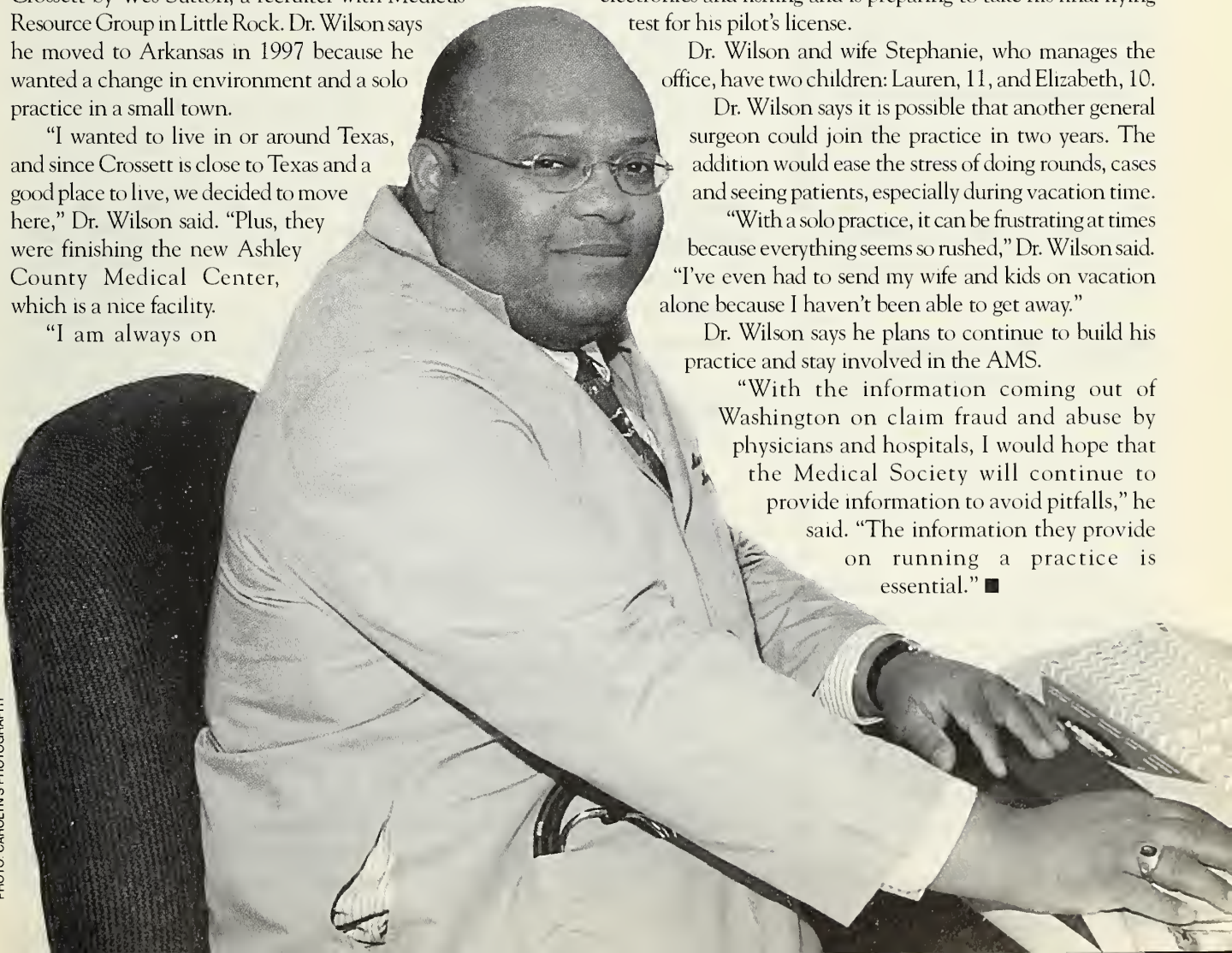
Dr. Wilson and wife Stephanie, who manages the office, have two children: Lauren, 11, and Elizabeth, 10.

Dr. Wilson says it is possible that another general surgeon could join the practice in two years. The addition would ease the stress of doing rounds, cases and seeing patients, especially during vacation time.

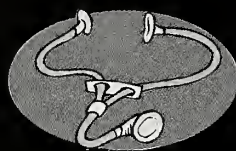
"With a solo practice, it can be frustrating at times because everything seems so rushed," Dr. Wilson said. "I've even had to send my wife and kids on vacation alone because I haven't been able to get away."

Dr. Wilson says he plans to continue to build his practice and stay involved in the AMS.

"With the information coming out of Washington on claim fraud and abuse by physicians and hospitals, I would hope that the Medical Society will continue to provide information to avoid pitfalls," he said. "The information they provide on running a practice is essential." ■



CARDIOLOGY



High-Output Cardiac Failure Related to Hemodialysis Arteriovenous Fistula

W. BRIAN BAILEY, MD — J. DAVID TALLEY, MD

Among the multiple etiologies for congestive heart failure in patients with end-stage renal disease, the contribution of hemodialysis fistulas to the myocardial work load is often overlooked. We recently cared for a patient with high-output cardiac failure from an arteriovenous fistula and review the features and pathophysiology of this condition.

Patient Presentation

A 54-year-old male with a long history of systemic arterial hypertension, diabetes mellitus and end-stage renal disease presented to the emergency department with a history of increasing dyspnea with mild exertion (see Table 1).

He was comfortable and vital signs were stable. A loud III/VI holosystolic murmur was present, but resolved with occlusion of his large arteriovenous fistula in his left forearm. A characteristic slowing in his heart rate was noted with occlusion of the fistula. His lungs were clear to auscultation. There was no peripheral edema.

His electrocardiogram showed si-

nus rhythm with biatrial enlargement, nonspecific T wave changes and a prolonged QT interval.

An echocardiogram showed a drop in his ejection fraction to 25%—

Table 1
Complete Problem List

1. Systemic arterial hypertension
2. Diabetes mellitus
3. End-stage renal disease

a. Hemodialysis

4. High-output cardiac failure

Etiology: Decreased systemic vascular resistance

Arteriovenous fistula

Anatomy: Echocardiogram; concentric left ventricular hypertrophy

Physiology: Echocardiogram; mild tricuspid and mitral regurgitation, left ventricular ejection fraction 25%

Objective: Severely compromised

Subjective: Moderately compromised

30% down from 55% just four months earlier. Mild mitral and tricuspid regurgitation were noted. Right heart pressures were: right atrial, 2 mmHg; right ventricle, 19/4 mmHg; pulmonary artery, 19/8 mmHg; and pulmonary capillary wedge pressure of 5 mmHg. His cardiac output was 9.4 liters per minute. The myocardial biopsies showed only myocyte hypertrophy.

In light of the elevated cardiac output in the presence of a dilated arteriovenous fistula high-output heart failure seemed to be the likely cause for the patient's declining cardiac function. Laboratory exams during this hospitalization ruled out other causes of high-output failure so vascular surgery was consulted for ligation of his AV fistula. A Tenchoff catheter was placed in preparation for the patient's change to peritoneal dialysis.

Discussion

Arteriovenous fistulas reduce systemic vascular resistance leading to a compensatory increase in cardiac output.² This is more pronounced in native vessel fistulas because of their

predisposition to dilate, while prosthetic shunts typically have a lower flow rate.³

Despite this decrease in systemic vascular resistance, these fistulas rarely result in high-output failure. Failure more often is seen in patients with a limited myocardial reserve.⁴ High-output failure from a dialysis shunt is seen only with a high shunt flow and one or more contributing factors such as coronary or hypertensive heart disease.¹ In our patient, systemic arterial hypertension may increase the flow through the low-resistance fistula leading to progressive dilatation and increasing myocardial demand.²

Many of the physical findings in these patients are no different than patients with high-output failure brought about by thyrotoxicosis, beriberi, Paget's or anemia, but one distinguishing finding is called Branham's or Nicoladoni's sign.⁵

This finding is defined as a drop in heart rate after occlusion of the arteriovenous fistula and is thought to be vagally mediated.⁶ This is caused by an abrupt increase in peripheral resistance, leading to vagal slowing of the heart rate through aortic and carotid pressoreceptors.⁸ This reflex appears to involve both efferent and afferent vagal pathways.^{7,4}

This effect is part of an overall decrease in cardiac output that is mediated by increased preload and a reduction in the inflow of blood to the right heart with subsequent decrease in distention of the ventricles in diastole.⁸ Findings common to all causes of high-output failure include widened pulse pressures, warm hands and feet, and a pulmonary flow murmur.¹ These features are notably distinct from those of low-output heart failure that we are quite familiar with, such as narrowing pulse pressures with declining stroke volume and cold, pale extremities secondary to declining peripheral circulation.¹

Appreciation that fistula-induced, high-output cardiac failure is dependent on both increased cardiac demand

and a limited myocardial reserve, the immediate treatment for this condition is surgical correction. Options range from excision of the fistula to banding of the fistula to reduce its flow.² A follow-up echocardiogram may be useful to verify recovery in the months after surgical correction. ■

Drs. Bailey and Talley are from department of internal medicine and division of cardiology, UAMS Medical Center and the John L. McClellan Memorial Veterans Hospital.

References

1. Lurie J, Sox H. High on the differential. *New Engl J Med* 1997;19:1377-1381.
2. Engelberts I, Tordoir J, Boon E, Schreij G. High-output cardiac failure due to excessive shunting in a hemodialysis access fistula: An easily overlooked diagnosis. *Am J of Neph* 1995;15:323-326.
3. Young P, Rohr M, Marterre F. High-output cardiac failure secondary to a brachiocephalic arteriovenous hemodialysis fistula. *Am Surg* 1998;64:239-241.
4. Braunwald E, Grossman W, Colucci W. Clinical aspects of heart failure. In: Braunwald E, ed. *Heart Disease* 5th ed. Philadelphia: W.B. Saunders, 445-448 1997.
5. Poepping I, Thalhammer C, Pilz B, Friedrich C. Cutting edge of cardiomyopathy. *Lancet* 1998;352:1518-1519.
6. Talley D. Whose sign is it anyway: Nicoladoni's, Branham's or both? *Res Staff Phys* 1996;4:29-31.
7. Gupta P, Singh M. Neuroal mechanism underlying tachycardia induced by non-hypotensive A-V shunt. *Am J Physiol* 1979;236:H35.
8. Epstein F, Shadle O, et al. Cardiac output and intracardiac pressures in patients with arteriovenous fistulas. *J Clin Invest* 1953;32:543-547.

2000 Shuffield Award

The Arkansas Medical Society is seeking nominations for the 2000 Shuffield Award, which will be presented at the annual meeting May 5-6 in Little Rock.

This award is given each year to recognize **laypersons** in Arkansas who have done outstanding community work in the health care field. The individual might be a newspaper reporter, television personality, government official, teacher or individual promoting a community or health-related program. The person **cannot be a physician or a physician's immediate family member.**

The nominations may come from a county medical society, AMS or alliance member.

All nominations must be received by Feb. 29, 2000.

Past nominees may be re-nominated. If you know someone worthy of this honor, please contact the AMS office at (501) 224-8967 or (800) 542-1058.

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RADIOLOGY



MR Cholangiopancreatography Is Important in Evaluation of Pancreatic and Biliary Systems

AUTHORS: STEVEN R. NOKES, MD — JOHN E. ALLEN, JR., MD — BRUCE JOHNSON, MD

EDITOR: STEVEN R. NOKES, MD

History

A 77-year-old female presented with abdominal pain and elevated liver enzymes. She had a long history of peptic disease and underwent a gastrectomy in the remote past. She developed bile gastritis and underwent Roux-en-Y conversion of her Bilroth operation and a cholecystectomy three years ago. A CT scan (not shown) was performed, followed by an MRCP (Figures 1 and 2).

Diagnosis: Choledocholithiasis.

Findings

The slab image reveals moderately severe dilatation

of the common bile duct (CBD) (18mm) with multiple CBD stones. Mild intrahepatic ductal dictation is present. The pancreatic duct is normal. The thinner slice (Figure 2) better defines the size and shape of the stones.

Discussion

MR cholangiopancreatography (MRCP) has become increasingly important in the evaluation of the pancreatic and biliary systems in the last few years, with the development of snapshot imaging. MRCP is noninvasive, does not require contrast administration and provides projectional images similar in appearance to the traditional meth-

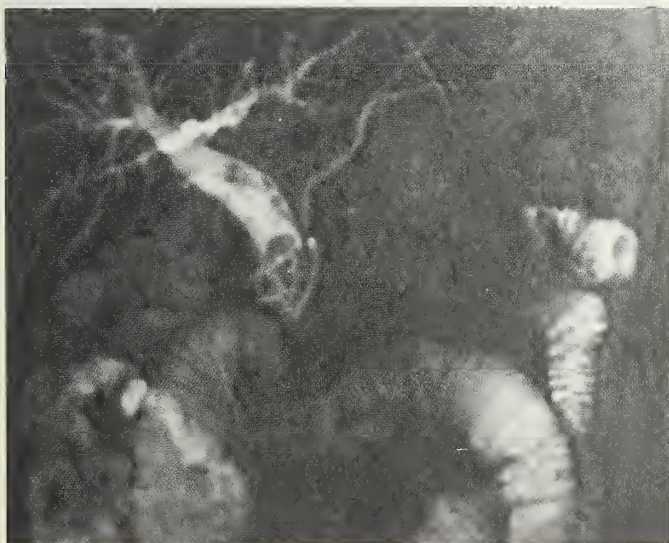


Figure 1. Coronal slab (60mm) single shot fast spin echo SSFSE T_2 -weighted image.

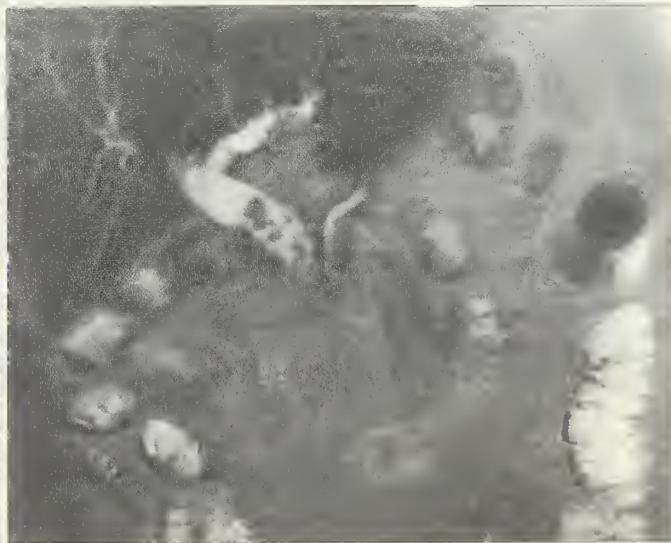


Figure 2. Coronal SSFSE T_2 -weighted image (5mm).

ods of endoscopic retrograde cholangiopancreatography (ERCP) and percutaneous transhepatic cholangiography (PTC).

ERCP remains the gold standard for evaluation of the pancreaticobiliary system. It combines excellent resolution with ability to distend the biliary system, visualize the ampulla, perform biopsies and institute therapy at the time of the diagnosis. ERCP is technically unsuccessful in approximately 5% of cases and carries a small (0.8%-5.0%) risk of pancreatitis or cholangitis. Patients with complex post-op anatomy (as in our case) cannot be evaluated by ERCP.

MRCP is performed using a heavily T₂-weighted pulse sequence that suppresses background tissues and accentuates stationary fluid. We use single shot fast spin echo (SS FSE) which collects all the phase encodings after a single radio frequency pulse resulting in an infinite TR. The TE is long (600-1,200). Both thick (60mm) slab and thin (3mm-5mm) breath hold coronal and axial images are acquired. Supplementary axial traditional images are obtained.

The other noninvasive modalities, CT and US, are insensitive to choledocholithiasis, with a sensitivity of 20%-80%. MRCP has a sensitivity of greater than 90%, which rivals ERCP. We currently perform MRCP when ERCP is unsuccessful, if there is pre-existing pancreatitis or if there is a low to moderate suspicion for common duct stones. ■

References

1. Reinhold C, Taourel P, Bet PM, et al. Choledocholithiasis: evaluation of MR cholangiography for diagnosis. *Radiology* 1998; 209:435-442.
2. Holzknecht N, Gauger J, Sackmann M, et al. Breath-hold MR cholangiography with snap shot techniques: prospective comparison with endoscopic retrograde cholangiography. *Radiology* 1998;206:657-664.
3. Bilbao MK, Dutter CT, Lee TG, Katon RM. Complications of endoscopic retrograde cholangiopancreatography (ERCP) a study of 10,000 cases. *Gastroenterology* 1976;70:314-320.

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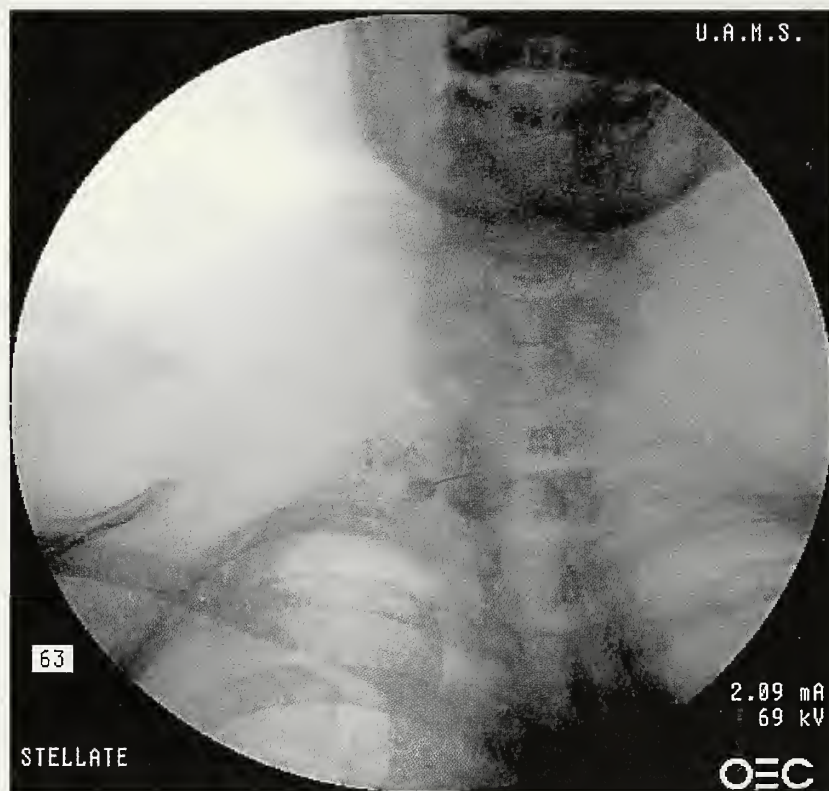
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Physiologic Effects of Stellate Ganglion Block: A Result of Complete Ganglion Blockade or the Vertical Spread of Local Anesthetic?

WILLIAM E. ACKERMAN III, MD, AND MAHMOOD AHMAD, MD



Needle placement with fluoroscopy. Injectate is directed in a caudal direction. Without fluoroscopic guidance the volume of injectate can progress in a cephalic direction, resulting in a Horner's syndrome without sympathetic blockage.

Abstract

Traditionally, stellate ganglion blockade has been used for the diagnosis and treatment of upper extremity sympathetic pain. However, this treatment has not been shown to provide adequate sympathetic blockade of the upper extremities. This study demonstrates that a carefully performed upper thoracic sympathetic block with imaging guidance can result in a successful sympathetic blockade of the upper extremities. This study furthermore demonstrates that the occurrence of a Horner's syndrome is not a testimony to a successful sympathetic block of the upper extremities.

Introduction

Stellate ganglion blockade with local anesthetics may relieve chronic sympathetically maintained pain involving the upper extremities. The American Medical Association

guidelines for impairment ratings of upper extremity sympathetically maintained pain (reflex sympathetic dystrophy) are based on the presence of a Horner's syndrome for confirmation of a successful stellate ganglion block.¹

Traditionally, blockade of the sympathetic innervation to the upper extremity required the administration of 10-20 ml of local anesthetic solution and testimony to a successful block was the appearance of a Horner's syndrome (miosis, ptosis, anhidrosis and vasodilatation over the ipsilateral side of the face).²

It should be noted, however, that the sympathetic innervation to the upper extremity arises from the lateral horn of the upper four thoracic sympathetic ganglia. Blockade of these thoracic ganglia seldom causes a Horner's syndrome. The standard technique (paratracheal approach) for doing

Table 1: Demographic Data of Patient Population

Sex Male: 21 Female: 29	Height (cm) 168.3 (±2.7)
Age 39.8 (±9.4)	Weight (kg) 77.3 (±5.8)

Table 2: Results of Cephalad Spread of Solution

Vertebral body level	Presence of Horner's Syndrome	Post-procedure Galvanic Response	Skin Temperature Increase
C3 (n=4)	4/4 ⁺ (100%)	0 (0%)	1/5 (20%)
C4 (n=6)	5/6 ⁺ (83.3%)	0 (0%)	2/7 (28.5%)
C5 (n=11)	8/11 ⁺ (72.7%)	2/11 (18.3%)	11/21 ⁺ (52.3%)
C6 (n=19)	12/19 (63.1%)	3/9 ⁺ (33.3%)	10/16 ⁺ (62.5%)
C7 (n=10)	5/10 (50%)	4/10 ⁺ (40%)	1/1 ⁺ (100%)
p ≤ 0.05			

Table 3: Results of Caudal Spread of Solution

Vertebral body level	Presence of Horner's Syndrome	Post-procedure Galvanic Response	Skin Temperature Increase
C7 (n=18)	6/18 ⁺ (33%)	3/18 (16.6%)	2/18 (11.1%)
T1 (n=10)	2/10 ⁺ (20%)	4/10 (40%)	3/10 (30%)
T2 (n=12)	0 (0%)	10/12 ⁺ (83.3%)	10/12 ⁺ (83.3%)
T3 (n=8)	0 (0%)	8/8 ⁺ (100%)	8/8 ⁺ (100%)
T4 (n=2)	0 (0%)	2/2 ⁺ (100%)	2/2 ⁺ (100%)
⁺ p ≤ 0.05			

stellate ganglion blockade is placement of a needle at the transverse process of the sixth cervical vertebral body (C6), which is identified by palpation of the Chassaignac tubercle. Typically 10-15 ml of local anesthetic is administered.² However, this technique, which frequently causes a Horner's syndrome, has been reported to seldom result in sympathetic blockade of the upper extremities.^{3,4,5,6}

Ackerman and Racz recently published data that placement of local anesthetic at the anterolateral aspect of the seventh cervical (C7) vertebral body resulted in a more successful sympathetic block for the upper extremity when compared to the conventional needle placement at the sixth cervical (C6) vertebral body.⁷

In spite of a higher incidence of successful sympathetic blockade when compared to the standard technique, these investigators did not consistently observe a Horner's syndrome. The purpose of this study was to observe the directional flow of contrast material mixed with local anesthetic in a vertical plane using fluoroscopy. Any physiologic changes associated with this procedure were recorded.

Methods

Fifty patients were studied after Institutional Review Board approval and informed consent was obtained. All patients had preprocedural physical findings of allodynia, hyperhidrosis, as well as a decreased temperature of at least 2°C in the extremity being studied. Each patient had a

Fifty patients were studied after Institutional Review Board approval and informed consent was obtained. All patients had preprocedural physical findings of allodynia, hyperhidrosis, as well as a decreased temperature of at least 2°C in the extremity being studied. Each patient had a preprocedural verbal assessment pain score (VAS 0-10) of 7 or higher.

preprocedural verbal assessment pain score (VAS 0-10) of 7 or higher. No patient had a preinjection skin surface temperature exceeding 33°C.

Each block was performed by the same anesthesiologist in a procedure room with ambient temperatures of 20°-22°C. Surface skin temperature was monitored bilaterally with liquid crystal temperature strips (Crystalline, Sharn, Inc., Tampa, Fla.). A galvanic skin response was assessed before and after the procedure.

A 22-gauge 3.5-inch needle was advanced to the anterior lateral border of the seventh cervical vertebral body at the level of the transverse process, under fluoroscopic guidance. After the vertebral body was contacted, the needle was withdrawn approximately 1 millimeter. A mixture consisting of 4 ml of bupivacaine 0.5% with 1 ml of Iopamidol 300 was injected. Under intermittent fluoroscopy, 5 ml of volume was administered at an injection velocity of 1 ml per 10 seconds.

Postinjection vertical spread in a cephalad and caudal direction was noted immediately and at 15 minutes. The vertebral body level obtained in both a cephalad and caudal direction was defined as the level of the transverse process above and below needle placement at the seventh cervical vertebra. The incidence of a Horner's syndrome, the presence of a galvanic skin response (pre and postinjection) and changes in skin temperatures were recorded. Statistical analysis was done using the complex Chi-square test with Yates correction for continuity when applicable. A p

value ≤ 0.05 was considered significant.

Results

Demographic data of the patient population is presented in Table 1. The incidence of a Horner's syndrome increased as the injected solution approached the level of third cervical vertebra (Table 2). Skin temperature increases in the absence of a galvanic skin response in the upper extremity were more pronounced when the solution spread distal to the first thoracic vertebra (T1).

Discussion

The above data demonstrated that the presence of a Horner's syndrome is not affirmation to a sympathetic block in the upper extremity. The results of our study suggest that temperature changes or absence of a galvanic skin response in the extremity blocked are more predictive of a successful sympathetic block than other physiologic changes. Effective sympathetic blockade of the upper extremity, however, can be achieved only with careful attention to technique.

Our results using imaging guidance with contrast material above C7 are consistent with the results of Stevens et al., who have reported that some doubt exists as to the success of the commonly performed paratracheal approach to stellate ganglion blockade in producing an adequate sympathectomy of the hand.⁴

Furthermore, Hogan et al. published another study in which a Horner's syndrome occurred in 84% of the stellate ganglion blocks, but a sympathetic block to the upper extremity occurred in only 27% of patients.⁸ They postulated that failure of stellate ganglion block was a result of an inadequate spread of local anesthetic to the sympathetic fibers, which travel to the upper extremity. Malmqvist reported an 87% incidence of producing a Horner's syndrome with stellate ganglion block but only 11.5% had a successful sympathetic block when performing stellate ganglion blockade without fluoroscopic guidance.⁶

Several approaches for the performance of a stellate ganglion blockade

have been described.⁵ We do not advocate one particular technique over another. We do suggest that spread of the local anesthetic distal to T1 along the anterolateral border of the vertebral bodies is essential to achieve a successful sympathetic block of the upper extremity.

This occurrence can be confirmed only with imaging guidance. The anterior lateral technique described by Ackerman and Racz using 5 ml of volume is used frequently at our institution to theoretically minimize local anesthetic plasma absorption kinetics, which should minimize the incidence of seizures related to a rapid uptake of the local anesthetic from a highly vascular area.⁷

Wulf et al. studied the plasma levels of bupivacaine after 10 ml of 0.5% bupivacaine were administered for stellate ganglion block.⁹ They found that 30% of their patients had toxic plasma levels of bupivacaine after the block. The risk of pneumothorax is minimized by the use of fluoroscopic guided needle placement.

Conclusion

The results of this study suggest that failure to produce an increase in skin temperature of the ipsilateral upper extremity and a negative galvanic skin response following a stellate ganglion block is due to lack of spread of the local anesthetic to the upper thoracic sympathetic fibers. We conclude that the results of a "successful" stellate ganglion block should include other criteria besides the occurrence of Horner's syndrome. ■

(This article was presented in parts at the 52nd annual New York Post Graduate Assembly, New York, December 1998; the American Society of Regional Anesthesia annual meeting, Philadelphia, May 1999, and the American Academy of Disability Evaluating Physicians annual meeting, Tucson, Ariz., November, 1999.)

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cal Sciences. Dr. Mahmood Ahmad is a fellow in Pain Medicine, the Center for Pain Medicine, Department of Anesthesiology, University of Arkansas for Medical Sciences.

References

1. The Musculoskeletal System. AMA Guides to the Evaluation of Permanent Impairment: American Medical Association, 1993: 56.
2. Harold B, Cousins MJ, Lofstrom JB. Sympathetic Neural Blockade of Upper and Lower Extremity. In: Cousins MJ, Bridenbaugh PO, eds. Neural Blockade in Clinical Anesthesia and Management of Pain. 3rd ed. Philadelphia: Lippincott-Raven Publishers, 1998: 428.
3. Elias M. The anterior approach to sympathetic ganglion block. *Middle East J Anesthesiol* 1997;14(2):99-105.
4. Stevens RA, Stotz A, Kao TC, Powar M, Burgess S, Kleinman B. The relative increase in skin temperature after stellate ganglion block is predictive of a complete sympathectomy of the hand. *Reg Anesth Pain Med* 1998;23(3):266-70.
5. Hogan QH, Taylor ML, Goldstein M, Stevens R, Kettler R. Success rates in producing sympathetic blockade by paratracheal injection. *Clin J Pain* 1994;10(2):139-45.
6. Malmqvist EL, Bengtsson M, Sorensen J. Efficacy of stellate ganglion block: a clinical study with bupivacaine. *Reg Anesth* 1992; 17(6):340-7.
7. Ackerman WE, Racz GB. Comparison of the efficacy of a low volume stellate ganglion block with a "traditional" technique. *Pain Digest*; 8:80-84.
8. Hogan QH, Erickson S, Haddox JD, Abram SE. The spread of solutions during "stellate ganglion" blockade. *Reg Anesth* 1992, 17: 78-83.
9. Wulf H, Maier C, Schele HA, Wabbel W. Plasma concentration of bupivacaine after stellate ganglion blockade. *Anesth Analg* 1991;72(4):546-8.



Possible vs. Appropriate

J. KELLEY AVERY, MD

During the act of opening the abdomen, the distal clamp came off the artery, with the loss of another estimated 500cc of blood and another hypotensive event.

The patient was a 48-year-old woman who had been seen for the last six years in the outpatient clinic of a major medical center where she was employed as a receptionist. On the first visit to this facility she was evaluated for mitral valve prolapse. The record does not detail the symptoms that brought her to examination by a cardiologist. An echocardiogram showed no evidence of prolapse; it was a normal study.

A year later she was seen in the outpatient center, where a pelvic ultrasound was done. Again the complaints that resulted in this examination were not a part of the record. However, the radiologist who performed the examination reported: "Impression: Moderately severe irregular uterine enlargement due to the presence of multiple fibroids. No adnexal masses."

During the next three years, this patient had three chest X-rays and a mammogram. The mammogram report was negative for malignancy but it did mention bilateral fibrocystic disease. The chest X-rays consistently showed "thoracolumbar scoliosis." The last report read, "Marked S-shaped scoliosis of the dorsal spine. No active disease."

Two weeks after this examination, the record showed that she was admitted to the hospital with a history of "pelvic pain." A history and physical examination revealed that this woman had the uterine fibroids first diagnosed five years earlier. She gave a history of "abnormal liver enzymes," and the examiner questioned whether she had a hepatitis screen done. No further comment appeared in the record relative to this, and no follow-up of liver enzymes was reported in the record preoperatively. She had been pregnant three times and had three children. Examination revealed the irregular multinodular mass in the uterus, which was said to be the size of a 20-week pregnancy. A total vaginal hysterectomy was planned, and possibly a bilateral salpingo-oophorectomy. The plan that the procedure would be a total abdominal hysterectomy appeared in the admission note.

She was a same-day admission for the sur-

gery, which turned out to be a laparoscopically assisted total vaginal hysterectomy. The attending obstetrician/gynecologist was assisted in the procedure by another gynecologic surgeon experienced in laparoscopic surgery of the pelvis.

At surgery, with observation through the laparoscope, the fibroid masses were seen to extend into both broad ligaments. The ureters were visualized throughout their normal course. The large fibroid on the left was first exposed, dissected free of the round ligament, with hemostasis secured by cauterization using a bipolar electrocoagulation device. Then the right mass was approached in the same manner, freeing it from the round ligament and securing hemostasis in the same way. This mass had to be dissected from the lower uterine segment using scissors. The surgical note then said, "Close to the completion of this task some bright red bleeding was noted to be coming from the left pelvic sidewall. Isolation of this area (still through the laparoscope) revealed a "nick" in the external iliac artery. Clamps were placed through the scope on both sides of the "nick" and a vascular surgeon was called, but one was not available.

A trauma surgeon answered the call and arrived in the operating room within 45 minutes. He came into the room, noted the condition, and suggested that the uterus be removed in order to more adequately expose the operative field. The surgeon then proceeded to scrub for his part in the procedure.

It was noted in the operative note that a hypotensive episode occurred about the time of the clamping to the artery. The precise timing of the injury to the external iliac artery in relation to the arrival of the surgeon was difficult to determine, but estimates of 30 minutes to one hour were given.

While the surgeon was scrubbing, the gynecologist was opening the abdomen through a Pfannenstiel incision. During the act of opening the abdomen, the distal clamp came off the artery, with the loss of another estimated 500cc of blood and another hypoten-



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sive event. Both such events were said to have responded to reclamping of the vessel and increasing the flow of fluids, both blood products and electrolytes. The surgeon attempted to repair the artery end to end but quickly determined that a graft would be necessary. Several times during the procedure, the operative note mentions "venous oozing." During the repair, the proximal clamp slipped off and more blood was lost into the wound. Estimates were in the range of 500cc.

At this point in the procedure, the operative report states, "Shortly after this small blood loss it was noted the beginning of EKG changes involving the ST segment. This rapidly progressed to ventricular tachycardia, which did not respond to cardioversion necessitating the start of cardiopulmonary resuscitation. The code team was summoned and after a prolonged coordinated effort of approximately 45 minutes, the patient was pronounced [dead]." Death occurred about three and one half hours after surgery began. The blood loss was estimated to be "1-2 liters."

A lawsuit was filed by the daughter of the patient charging negligence on three counts: Negligence in undertaking an inappropriate laparoscopic procedure; negligence in performing the laparoscopic procedure, and negligence in the attempted repair of the injured artery.

The charge against the surgeon who attempted the vascular repair was dropped.

In the opinion of the experts, the choice of the laparoscopic approach was a mistake because of the size of the fibroid uterus (20 weeks gestation by ultrasound), and due to the size of the tumor, the procedure was negligently performed.

Loss Prevention Comments

The description of the multinodular fibroid uterus and its size should

have led the initial ob/gyn surgeons to very carefully evaluate the choice of procedure, whether as an open operation or the more difficult laparoscopic-assisted total abdominal hysterectomy. All of the experts, even those chosen by the defense, questioned the decision, since even though it would be possible, it would carry a greater risk. The preoperative record did not reveal any documentation of an informed consent discussion.

One must wonder whether the possibility of the laparoscopic

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hysterectomy.**

procedure with its advantages was not oversold to the patient. Frequently, patients have heard of this kind of surgery and request it on the basis of the reports of friends of less pain, less lost time from work, and the like. Had there been a frank and open discussion of the planned laparoscopic procedure and the risks with this size lesion, along with the customary expected advantages, the lawsuit probably would not have been filed.

With the size of the lesion, visualization through the laparoscope must have compromised the surgeon's ability to expose the deep pelvis. The operative note pointed out that the fibroid nodules had invaded both round ligaments, and

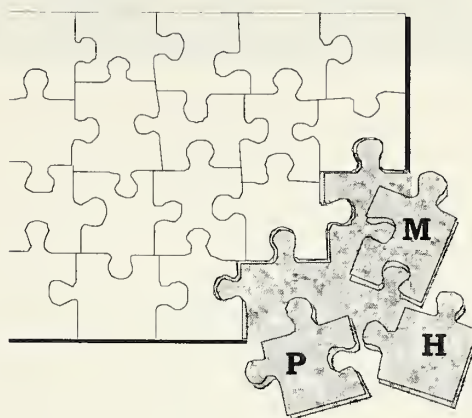
forced the use of sharp dissection in the exposure. Having first dealt with the left side of the pelvis, the surgeon then turned his attention to the right side, so that the bleeding on the left was not discovered until "close to the completion of this task."

Although the estimate of the bleeding was rather conservative, the first hypotensive episode occurred during that time. Had the operation been done through an open incision, visualization and manipulation of the tumor would have been much easier, and the likelihood of injury to the iliac vessels much less. Probably the application of the clamps through the laparoscope, and the subsequent use of a Pfannenstiel incision, made the clamp slipping off the vessel more likely. Experts were critical of the use of that incision, pointing out that it provided less exposure and usually took longer. There is universal agreement that arterial bleeding noted through the laparoscope is a severe vascular emergency, and the faster and wider the exposure of the bleeding vessel, the better the chance of a favorable outcome.

Although there was conjecture as to the cause of death in this patient, whether it a cardiac event or hyperkalemia from the transfusions required during the operation, the essence of this case was the choice of the laparoscopic approach over an open operation, and the limitations that choice put on the operating team. This case clearly demonstrates that what is possible is not always appropriate. Although there was no settlement or judgment in this case, the ob/gyn surgeons were involved in a long and expensive litigation process. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the March 1999 issue of Tennessee Medicine. It is reprinted with permission.

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College of Surgeons Inducts LR Doctor

Dr. Gene Sloan of Little Rock was among 1,491 physicians who became fellows of the American College of Surgeons recently during the Clinical Congress in San Francisco.

Dr. Sloan, who graduated from the University of Arkansas for Medical Sciences in 1985, is certified by the American Board of Plastic Surgery. He's also a member of the American Society of Plastic and Reconstructive Surgeons, American Society for Aesthetic Plastic Surgery, Lipoplasty Society and the Arkansas Medical Society.

LR Urologist Named to Office

Dr. John F. Redman, professor of urology and pediatrics at Arkansas Children's Hospital and the University of Arkansas for Medical Sciences, recently was named president of the South Central Section of the American Urologic Association. He also recently was inducted as a fellow of the Society of Pediatric Urology.

Orthopaedic Society Elects Officers

Dr. David Gilliam of Little Rock recently was elected president of the Arkansas Orthopaedic Society for 2000-01.

Dr. Jim McCoy of Searcy was elected vice president, and Dr. Scott Cooper of Rogers was

chosen secretary/treasurer. Dr. John Lytle of Pine Bluff is on the American Academy of Orthopaedic Surgeons Board of Councilors.

The Arkansas Orthopaedic Society's 2000 meeting is scheduled for Dec. 8-10 at Five Oaks Lodge in DeWitt.

Greenwood Honors Fort Smith Doctor

Dr. Art Martin of Fort Smith recently received the Greenwood Education Foundation's Distinguished Alumni Award.

Dr. Martin, a 1935 graduate of Greenwood High School, was responsible for preserving the clock from the old South Sebastian County Courthouse, which was destroyed by a tornado in 1968. The clock is in working order in a park on the square.

Dr. Martin also is president of the Fort Smith Streetcar Restoration Association, which runs a trolley museum and half a mile of trolley track.

OBITUARIES

Walter L. Walker, MD

Dr. Walter L. Walker, 79, of Brinkley died Nov. 30.

Dr. Walker, who began his practice in Brinkley in 1945, retired in 1992 after a stroke. He was a veteran of World War II and a member of the Arkansas Medical Society and the American Medical Association.

He was former chief of staff and a member of the advisory

board at Delta Medical Center, where he also served at various times as chief of obstetrics, director of the respiratory department and a member of the hospital commission board. He also was former health director for the city of Brinkley.

Dr. Walker is survived by his wife, Freddie Collom Walker, and two sons.

I.L. Carlton, MD

Dr. I.L. Carlton, 75, of Little Rock died Dec. 31.

Dr. Carlton was a member of the Arkansas Medical Society, the American Psychiatric Association and a veteran of World War II.

He is survived by his wife, Norma Jean Carlton, and three daughters. ■

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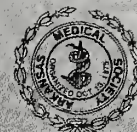
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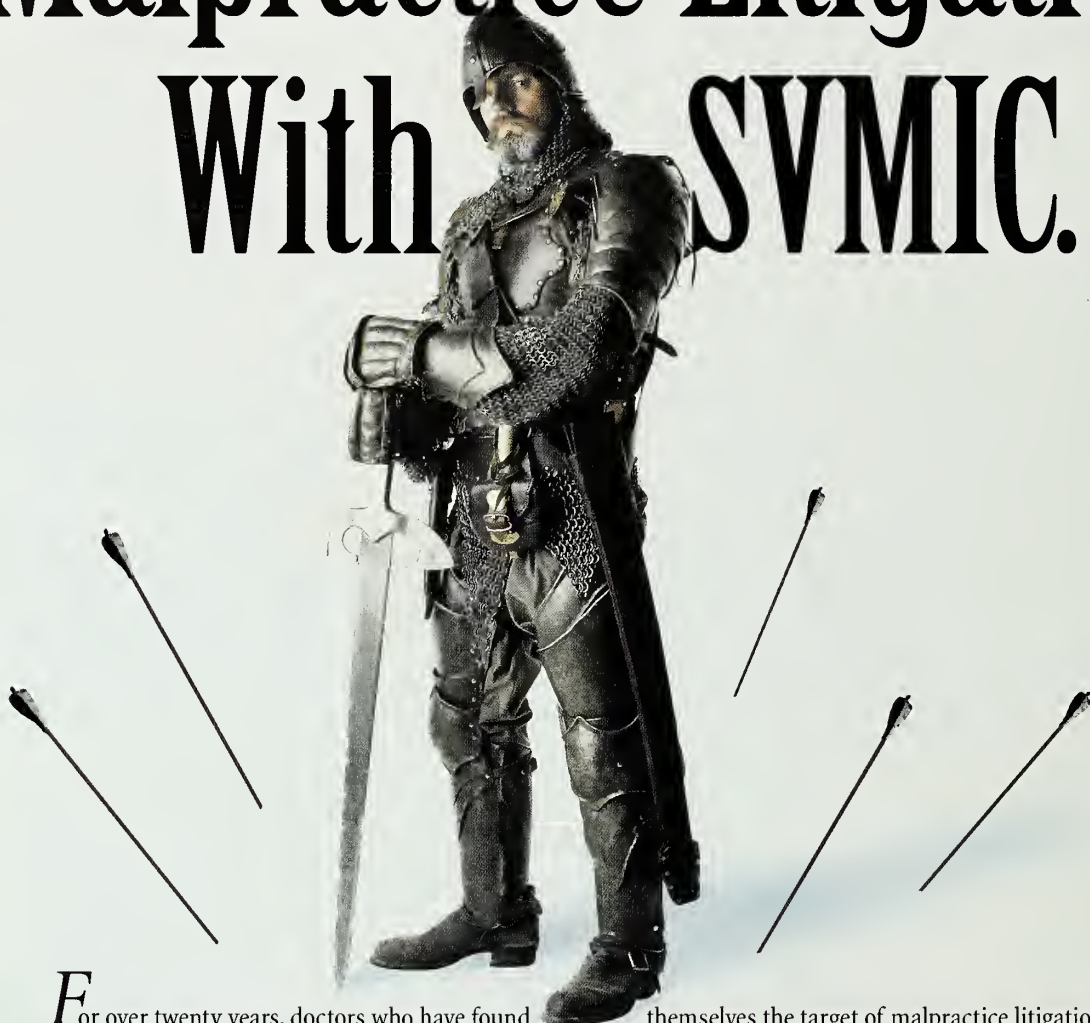
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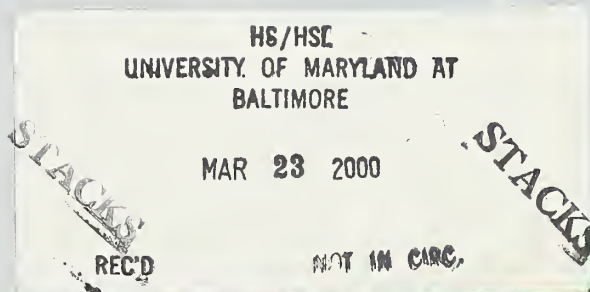
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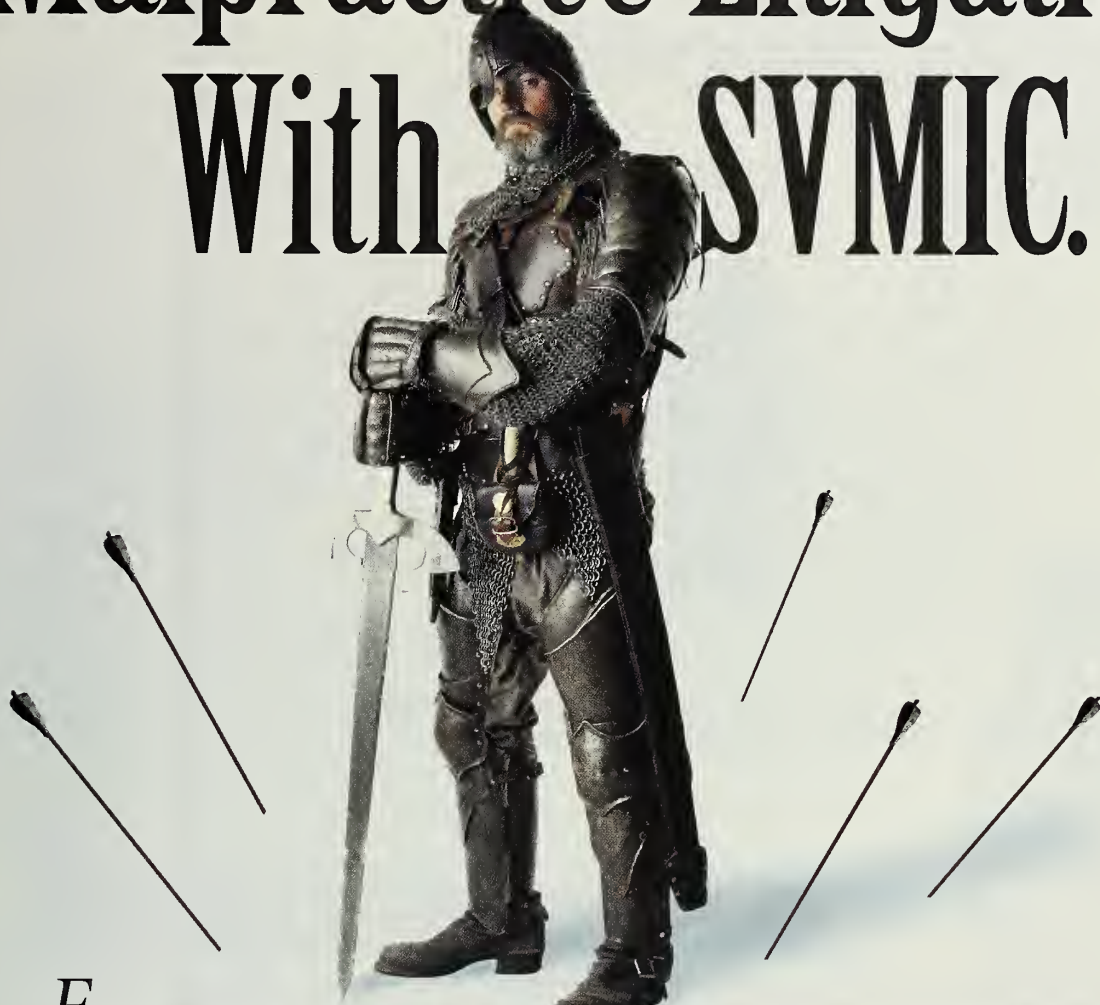
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THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

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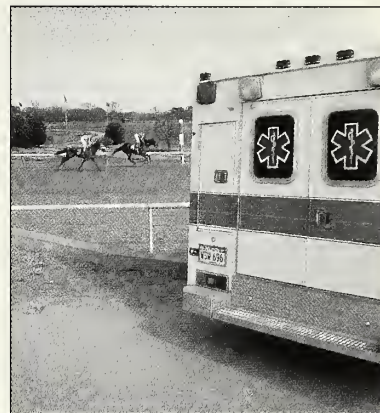
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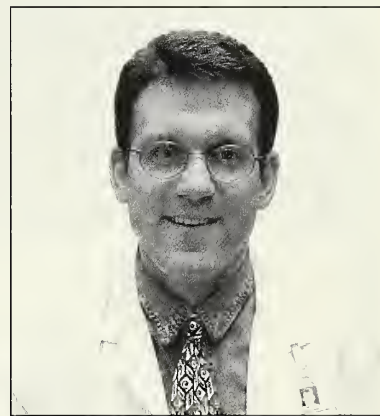
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*On the Cover: Oaklawn EMT Ryan Hamilton keeps a watchful eye on the track.
Photo by Spencer Tirey.*



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COMMENTARY

On Saying Goodbye

JERRY KENDALL, MD

I can't really remember when I began wanting to be a doctor. One of my earliest recollections is carrying a toy black bag around and being called "Little Doc" by the people in the small town where I grew up. From that time on, no matter what direction my life was going at the time, that burning desire was always foremost.

The preparation for this career was a short-term goal: Going to college and then medical school, and finally internship and residency. Then suddenly one day I was where I had dreamed of being all my life, a *bona fide* physician in private practice.

For many years medicine gave me all the pleasure and fulfillment that I knew it would, and I never saw myself retiring from something that I liked so much. Then, very insidiously, things began to change. My health began to decline, and my energy for work became less. The numerous changes that occurred in the delivery of health care became more onerous, and I was unable to cope with them as well as I should have. My interests in outside activities became heightened, and I discovered another world apart from medicine.

For the first time, I began to consider retirement and the ramifications it would have on my life. One of the advantages that I had over many of my colleagues was my interest in many other areas and my ability to do different things, which had been forged by my experiences in several other jobs on the way to my career. I thought I knew that I could stay active and vital while doing some things that I enjoyed, but I felt a small pang of conscience because I felt that I somehow was deserting a sacred grail that I had worked so hard to achieve. I was concerned that my patients would feel that I was deserting them and was worried that they could not find continuing care in a market that had many more consumers than providers.

But the feeling that I needed to get out while I was still a pretty good doc was persistent, and I compromised for a year by working only two days a week in the office. At first all I did was compress a full week into two days, and I had to set limits as to what I could do. I became acclimated to the time off and found that I filled every spare minute and still did not have enough time to do all the things I wanted. This gave me the courage to set the end of the year as the time for my permanent retirement.

As the time approached — instead of wondering if I was doing the right thing as I had feared — I became more convinced than ever that this was what I needed to do. And so, on my last day, as the staff at my retirement party shed tears, I had a smile on my face. I have to admit that it was bittersweet and I knew that there were relationships and friendships that I would sorely miss, but I also knew that additional areas for these would open up in this latest phase of my life.

Four weeks ago I listened to my last chest, palpated my last abdomen, signed my last form, talked to my last insurance company representative and read my last notice from Medicare explaining what they would not pay for. How do I feel? Great! I have gotten up earlier, worked harder and felt better than I have in years. I have not had time to reflect on the things that I would miss if I were to let myself think about it. I may have a different view in the months to come, but for now I think I did the right thing at the right time. ■

Dr. Kendall is a retired family practitioner from Camden. He is a member of the editorial board for The Journal.

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Annual Session with a New Twist

BY DAVID WROTEN

In this issue of *The Journal*, AMS members will get their first opportunity to register for the 124th Annual Session of the Arkansas Medical Society. The meeting is scheduled for May 5-6 at the Embassy Suites in Little Rock.

Over the past couple of years your leadership has sought input and comments on ways to make the annual meeting more valuable to you.

The first thing you will notice is that all of the business meetings of the Society have been rolled into one day. Members who traditionally have attended only the business meetings can do so without taking up their whole weekend. In the past, meetings of the Council and House of Delegates have been spread over two or three days.

On the other hand, some physicians who aren't that interested in the business meetings, attend annual session for the continuing medical education programs and have asked for more hours. This is even more important today since the Arkansas State Medical Board now requires physicians to have 20 hours of CME each year to be licensed. To address that need, we have increased the number of hours and combined all educational programs into one day.

The entire meeting has been reduced to only two days, with the educational programs on Friday and the business meetings on Saturday. The educational programs have been designed to address cutting-edge medical issues and technology, such as gene therapy and the use of the Internet as a tool for delivering efficient, high quality health care.

A common misconception of some physicians has been that the AMS annual meeting is mostly for elected delegates. Hopefully by scheduling a full day of educational programming, members around the state will be more inclined to attend. You can register just for the educational programs, the business meetings or both.

For fun, members and their spouses can attend a special night at the Arkansas Repertory Theatre featuring a performance of "Blues in the Night."

Whether you come for one day or both, please come. The AMS annual meeting is an opportunity to spend time with friends, make new friends, learn more about your Society and attend top-notch CME programs. So mark your calendars for the 124th AMS Annual Session 2000 & Beyond, May 5-6, 2000, Embassy Suites, Little Rock. ■

Look for the special registration information included in the center of this issue of *The Journal*.



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Against All Odds

Medical Providers Keep Watch as Jockeys Bet Their Health on Winning Rides

By Lance Turner

Clutching their racing forms and ticket stubs, it might be easy for thoroughbred racing's casual observers to forget that the possibility for disaster exists each time a horse and rider trots onto the track.

Raw power accompanies the grace and majesty these animals carry, often making them as dangerous as they are beautiful. It's a side of the sport few in the stands think about.

Chuck Jones, director of emergency medical technicians at Oaklawn, must be aware of that. Jones has been at Oaklawn for 12 years. During racing season, he can be found near the southwest corner of the track atop a concrete knoll that spills onto the apron of the oval.

There, he and a small team of EMTs await any accident. Jones' team watches closely as the horses thunder past, kicking up clumps of dirt like small, dark sparks. They're riveted; their interest nailed down to the track like a bettor who's last dollar's on the table. But Jones and his EMTs aren't at Oaklawn to play the ponies, though they would never debate the value of what's at stake.

At a Moment's Notice

Jones was not new to the horse racing scene. He used to come to the track with his father when he was a child. He says he likes the pretty sunrise and the calm of the track in the morning. He says he likes to watch the horses, which often hit the track with their trainers about 15 minutes before dawn for a misty morning run.

It is during these mornings however, that Jones says most of the spills — accidents involving horse and rider — occur. The horses are fresh in the morning, just getting out for a first stretch of the legs. And a blanket of morning fog might drape on the trees and across the track, limiting visibility. Even at 5:30 a.m., still groggy from sleep or a shift on duty for the local ambulance service, the EMTs must be alert.

This season, Jones says, they've had about 10 spills on the track.

"This year's been a little better than usual," he says.

Not all the spills, of course, demand a trip to the emergency room. But Jones says the EMTs often make about 100-130 trips a season. This year, however, the Oaklawn racing season is shorter — 52 days. Jones says he expects to make about 100 runs to St. Joseph's Regional Health Center in Hot Springs.

Also on hand at Oaklawn is the track's director of security, Charlie Evans.



Once a race is underway at Oaklawn, an ambulance is ready to go out on the track at a moment's notice.



Photo: Spencer Tiney

The EMTs, he says, operate as part of his security team. And Evans' security officers, in turn, help alert EMTs to medical emergencies. Along with the EMTs and security officers, Arkansas Medical Society member Dr. John Haggard, a retired gynecologist, mans the first aid room, where he treats sick or injured spectators.

Three volunteer firefighters are part of Jones' team. They use the work at Oaklawn to help them maintain their EMT skills. Others on the team are from the Hot Springs National Park or St. Joseph's Regional Health Center.

Ready to Roll

Near the track, one ambulance, licensed for transport, is ready to roll at a moment's notice. It's only about a three-minute drive from the apron of the track. During the races, two EMTs man the ambulance, ready to cruise onto the track at the sight of a jockey down, a radio call from a sharp-eyed steward or the sounding of an alarm, which alerts EMTs to trouble during morning trainings. Jones says on the first Saturday of racing, his crew hit the track three times.

But it helps that the jockeys are prepared for accidents, Jones says. These riders are, after all, professionals who take their sport, and their safety, seriously. In addition to the traditional helmets, the jockeys are equipped with breastplate-like devices called flat jackets. Like football players, the jockeys are protected from most trauma by the padding the equipment provides. Worn under the loud colors of their silk jerseys, the flat jackets protect the jockeys from broken ribs and other serious injuries. Often, jockeys walk away from spills with only a few cuts and bruises thanks to the flat jackets, Jones says. The jackets are made of a honeycomb-type padding, which absorbs and evenly distributes the shock of the trauma throughout the jockey's torso. If a horse kicks a jockey, Jones says, the jacket "spreads out the actual thrust of the kick."

The number and severity of spills often depends on the weather and the condition of the track, Jones says. The jockeys are aware of that, and some might not wish to ride if the track is wet and muddy, which could cause horses to slip. But when injuries are serious, they often involve the legs, collarbone or neck. Jockeys also can be in danger of horses spooked by shadows, causing them to fall, roll end-over-end or trample the riders.

Evans says jockeys are clear on what they must do to protect themselves during a spill.

"When they hit the ground they know: Don't move," he says. Jockeys are well aware of the dangers spinal cord and neck injuries pose. A wrong move without medical assistance after a hard fall could leave a jockey paralyzed. But when they fall in the path of other thoroughbreds, jockeys know to roll to the inside of the track to avoid being trampled, Evans says.

Injured Egos

Once EMTs reach a jockey down on the track, Jones says the emotions can be mixed. A look at the payoffs the



Photo: Spencer Tirey

Oaklawn EMT Ryan Hamilton has to stay alert at all times; an accident involving a jockey can happen at any time.

horses bring and the investment they represent to their owners will illustrate to anyone that there's more at stake at Oaklawn than a simple win.

Jockeys are tough competitors, Jones says, as stubborn as any football player. "These jockeys are notorious for not going to the hospital," Evans says.

"They don't like seeing us come up," Jones says. "We're like the kiss of death for them."

For that reason, the EMTs like to get to know the jockeys as well as possible. Building camaraderie, trust and respect is important, he says. Such personal relationships help make the EMTs' job of treating jockeys easier.

Even little details, like having new, up-to-date equipment, also helps build relationships between the athletes and

medical personnel, Jones says. For example, the EMTs recently received a new ambulance, which replaces the two older models from 1970 and 1972.

Jones says that helps the atmosphere when dealing with the jockeys, who are reassured by the new equipment and feel they are in good hands. Because every track has different safety practices (at some tracks, the EMTs will follow the horses on the track as they run the race, Jones says), it's important that the jockeys are confident about the medical help they receive, he says.

Spectator Sport

But jockeys aren't the only people the EMTs are watching out for. Everyone from race fans to assistant starters are possible emergency cases. Jones tells a harrowing story of one man who got caught in an uncomfortable — and dangerous — situation.

The man, an assistant starter, was

charged with helping the horses and jockeys in the gate before beginning the race. While inside the gate with the horse and rider, the horse became nervous, turned around and flipped. The assistant starter was trapped between the horse and the gate. The EMTs and other assistants had to respond quickly to pull the man to safety.

Thus, Jones says, it's important the EMTs work well with everyone involved in the behind-the-scenes work at the track.

The good working relationship among track personnel (including security officers and Dr. Haggard) helps EMTs be prepared to handle most of the emergencies at the track. Jones says he works with Evans' security staff on learning to transport victims and handle basic emergency procedures. Jones says that it helps the security staff feel more comfortable in helping the emergency personnel.

Jockeys are well aware of the dangers spinal cord and neck injuries pose. A wrong move without medical assistance after a hard fall could leave a jockey paralyzed.

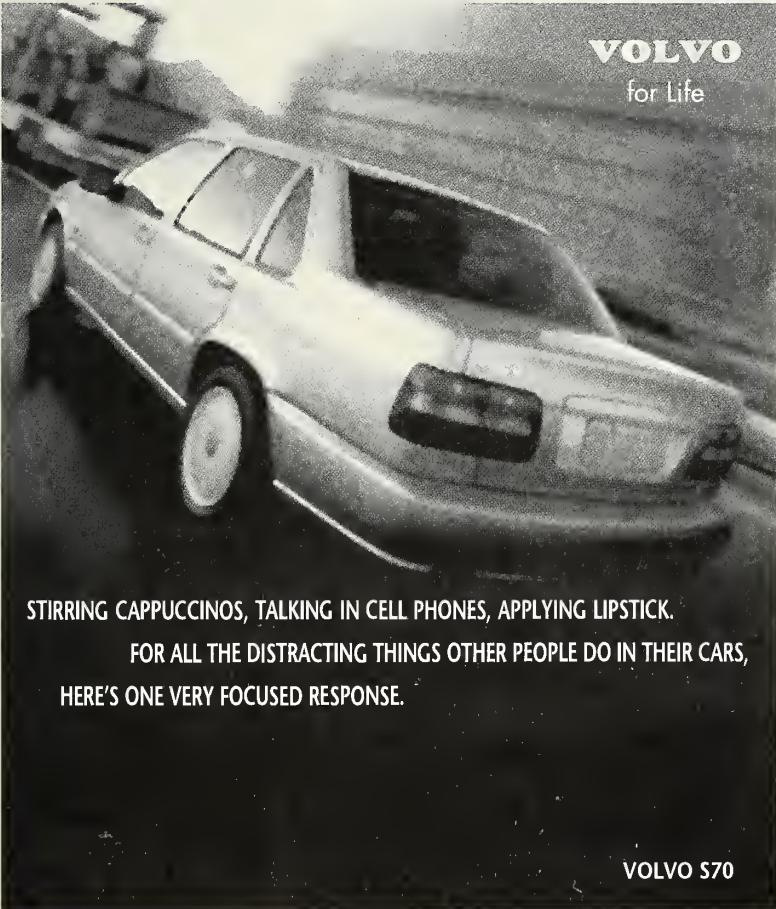
Thus, Jones says, Oaklawn personnel are prepared to deal with most problems, including those in the stands and near the betting windows. Inside the building on the weekends, one EMT might be available. That person, of course, must watch 15,000-20,000 people. Again, Jones says, the EMTs must cooperate with others at the track to help those in need. Security guards are often the first to reach someone in an emergency situation.

Evans says the track often sees two to three heart attacks per year. But he

boasts that the heart attack victim is probably safer at Oaklawn than he might be at home. With EMTs nearby, Jones says race fans can count on a quick response — no more than three minutes. And it's only another three minutes to the nearest hospital, he says.

During the off-season, when the track is taking bets for simulcast racing, security guards must rely on 911 to handle emergency cases.

But Jones says that whenever a horse is on the track, his team is always on the lookout. ○



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Meet Our Members

Hugh Jackson, MD

BY PATRICIA MAY

Dr. Hugh Jackson describes himself and his two partners as “weirdos,” but he means no insult by that.

Dr. Jackson, who practices in Fort Smith, believes his area of specialty, family practice, should include people at every stage of life, from cradle to grave.

“Not to do obstetrics and pediatrics in your family practice, to me, that’s not really my idea of what family practice is,” Dr. Jackson says. His view that family practice should be a comprehensive practice is shared by his partners and one that sets the trio apart from many of today’s modern family practitioners.

But then, Dr. Jackson’s been a bit nontraditional since first embarking on a medical career.

A native of Texarkana, Texas,

he says he wanted a career in the health industry but he wasn’t sure in what capacity. While Lori — his high school sweetheart who later became his wife — studied for a degree in teaching, Dr. Jackson got an associate’s degree in nursing and then went to work as a nurse.

Dr. Jackson continued to work as a nurse while completing his undergraduate degree (a major in biology and a minor in chemistry) at the University of Arkansas at Little Rock and up through his junior year of medical school at UAMS.

It was a move, he believes, that was beneficial.

“I’m grateful for my years in nursing,” Dr. Jackson says, noting that he worked at Little Rock’s St. Vincent’s Infirmary Medical Center, Doctors’ Hospital and UAMS Medical Center.

Dr. Jackson’s first choice for his residency training was with AHEC in Fort Smith, where the family practice program offers comprehensive care training with a particular emphasis on obstetrics. As he neared the end of his residency, however, he found that his ideas about family practice didn’t mesh with those of physicians who were already practicing.

“I was talking to physicians with established practices and they all seemed to be lacking in what my expectations were,” he says.

That’s fine for those physicians and their patients, Dr. Jackson says, but it wasn’t what he wanted. Still in quest of a womb-to-tomb practice where he could build long-term relationships with his patients, Dr. Jackson began to explore the idea of establishing his own independent practice. He talked to his

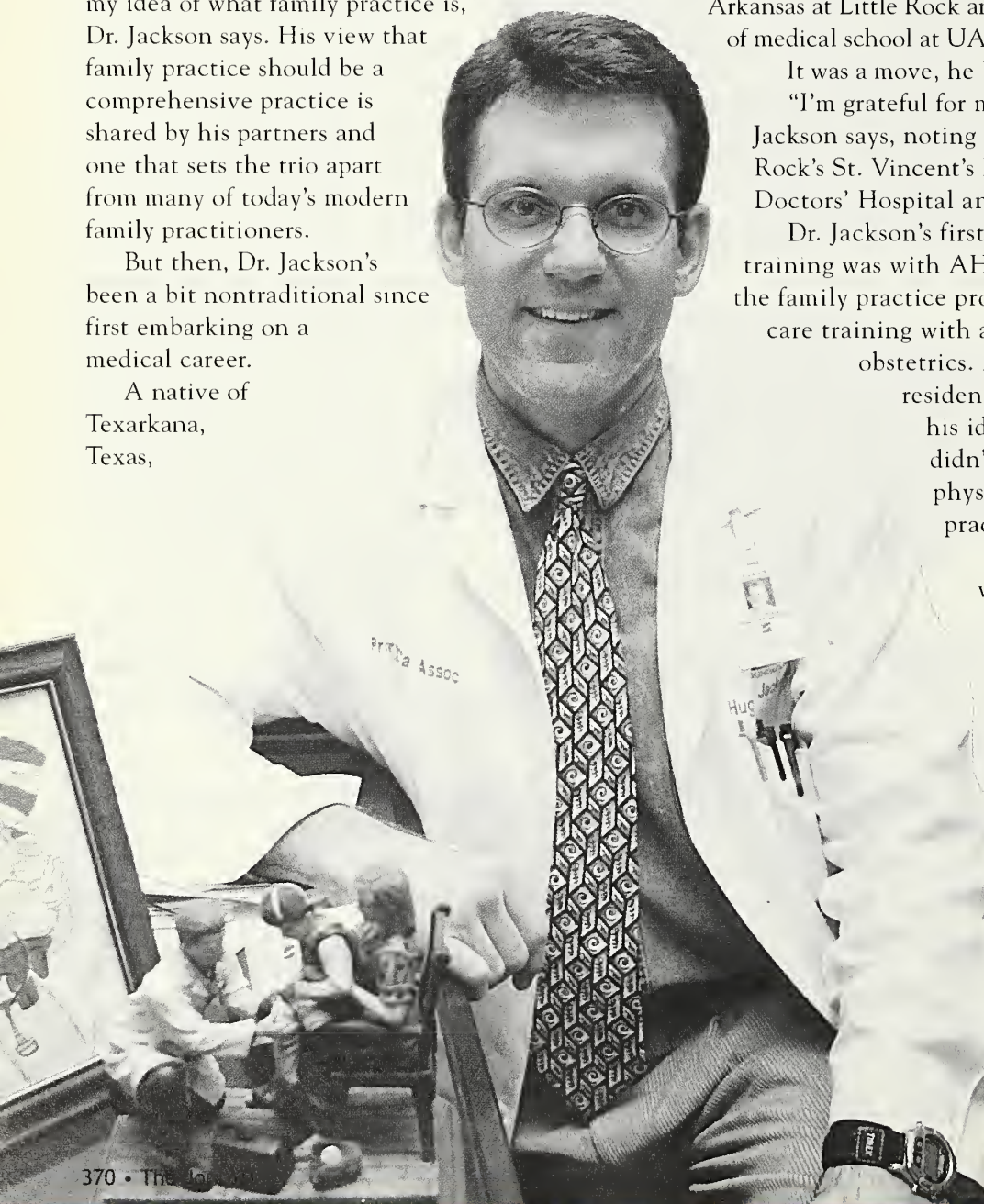


Photo: Kirk Jordan

fellow residents to see whether any of them shared his philosophy.

Most planned to join already established practices, but one fellow resident, Dr. Vikki Sutterfield, did share Dr. Jackson's views about patient care.

Two other residents suggested he talk with Dr. Jeff Floyd, who, like Dr. Jackson, was chief resident of his hospital. The two men met at a Salt Lake City, Utah, conference and hit it off immediately.

"We just shared so many of the same ideas," Dr. Jackson says. "He had many of the same ideas I did."

The trio began talking about practicing together. Dr. Jackson tapped his contacts in town to find support staff and, with initial financial support from Sparks Medical Foundation, the three new doctors opened the doors of their office, Primary Care Associates, last July, just after finishing their medical training.

"We're brand spanking new," Dr. Jackson says. "We're all green as can be and we're glad of it," he adds, referring to the idealistic goals the three share.

But the caseloads are building, and each of the three doctors sees, on average, 20 to 25 patients a

day, a healthy level for physicians at this early stage of their careers, he adds.

"We're very pleased where we are right now," Dr. Jackson says. In addition to doing obstetrics as part of family care, Dr. Jackson does endoscopies — and his partners will also soon. The three physicians have nursery care privileges at Sparks Medical Center.

Dr. Jackson and his partners also are interested in taking active roles in the Arkansas Medical Society and community groups because they believe their patients will benefit from their involvement.

Dr. Jackson's been nominated as a delegate to the Arkansas Medical Society, and he believes the nomination alone is a great honor.

"I'm privileged and lucky" to have been nominated, he says.

Dr. Jackson, who still has hopes of someday practicing independently rather than under contractual agreement, also wants to be active on a national level.

Health care, he says, "is really in a state of crisis." It's a topic that's been too politicized, he notes, and action, not just talk, is needed.

Dr. Jackson and his wife, Lori, have two daughters, Lauren, 9 and Abby, 1. ■

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Inattentive to Essential Details

J. KELLEY AVERY, MD

The patient was admitted to the hospital, where a bronchoscopy showed no intrabronchial lesions. The upper lobe of the right lung was resected, with the adjacent pleura and the attached portions of the second and third ribs. Two normal appearing lymph nodes were removed.

A 46-year-old construction estimating project manager reported to his family doctor complaining of pains in his legs and knees for a month. Some swelling had begun to occur about 10 days before this visit, and he had developed some pain in both calves. He had continued to work, performing his duties as usual even with the pain. He noted that the swelling would go away at night. He had high blood pressure, for which he was taking a beta blocker.

The physical examination was reported as "negative" except for some tenderness in both legs and some minimal swelling in his ankles. He refused a "prostate check." A "rheumatoid profile," complete blood count and a chest X-ray were ordered, Indocin was prescribed, with Tranxene 15 mg three times a day. A week later he came to the physician's office for a blood test. No tests or results of any appeared in his chart.

Two months after his initial visit he requested a refill of his "pain medicine," presumably Indocin. A week later he reported to his physician with pain "under the right axilla." There was no documentation of physical findings, but the diagnosis recorded was "degenerative arthritis and anxiety." The same medications were continued, and no appointment for return was recorded. Between this visit and his visit to another doctor 14 months later, the patient had requested and received seven refills of his tranquilizer and Indocin.

There was an entry in the medical record that the patient was to be seen before any more refills were authorized.

Two weeks later he presented to the doctor's office for a physical examination "under his plan."

The patient was given his previous chest X-ray and the finding of a "place on the film" was "discussed in detail" with him, and a consultation was arranged by the attending physician. At the initial visit the con-

sultant took a thorough history in which the joint pains were recorded and the statement was made, "Indocin with superb results." The pain in the upper right chest was documented as having begun about a year previously, and while the medication seemed to help for a while, lately it had not seemed to be as effective. The pain seemed to have no relationship to movement or position.

He was a one-and-a-half-pack per day smoker without significant sputum production, and he had no shortness of breath or chest pain even on hard physical exertion. History revealed no surgical procedures and only one hospital admission for hypertension 20 years before. This was attributed to job stress. There was a family history of tuberculosis, cancer, hypertension and arteriosclerotic heart disease.

Physical examination revealed some signs of degenerative joint disease, and a reduction of breath sounds was noted in the right upper supraclavicular area. The chest X-ray revealed an "infiltrative process in the right upper lobe," which seemed to involve the adjacent pleura. The pain in the area had become somewhat pleuritic but was still not affected by position. The history of arthritis was noted, and that the previous physician had ordered an antibody test for rheumatoid arthritis, which was reported positive.

A CT of the chest showed a noncalcified mass in the right upper lung field, with involvement of the chest wall. A biopsy showed adenocarcinoma of the lung, but a bone scan showed no metastases.

The patient was admitted to the hospital, where a bronchoscopy showed no intrabronchial lesions. The upper lobe of the right lung was resected, with the adjacent pleura and the attached portions of the second and third ribs. Two normal ap-

pearing lymph nodes were removed. The pathologic diagnosis was adenocarcinoma, without involvement of the ribs or lymph nodes. The postoperative course in the hospital was uneventful, and he was discharged five days after surgery.

Within two weeks of the patient's discharge from the hospital, a medical oncologist discussed in detail the options they faced in his further treatment using chemotherapy and radiation. The patient refused chemotherapy, but when some hope was held out for radiation therapy, the patient was seen by a radiation oncologist. Although the prognosis for this modality of treatment was described as poor, all the physicians involved, as well as the patient himself, decided it was the best choice.

The patient was seen regularly by his medical oncologist during the course of radiation treatments. He seemed to do well, and completed all the recommended treatments, and there was genuine surprise on the part of the physicians at how well he did. At six months after surgery the physical examination was negative for any progression of his disease, and MRI showed no evidence of metastasis. At a year, the medical oncologist made mention of only some bronchitis, which he believed was due to the radiation. He remained disease-free during follow-up.

A lawsuit was filed charging the primary care physician with negligence in failing to diagnose the lung cancer and initiate treatment in a timely manner. All the reviewers of this case agreed that on the chest X-ray taken in the office of the family doctor, an abnormality should have been suspected, which should have resulted in earlier diagnosis and treatment. The plaintiff contended that the delay resulted in

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Loss Prevention Comments

The old adage that, "If it was not documented, it was not done" almost always remains the rule when litigation occurs. Documenting details seems much more of a chore than it really is. When no comment appears in the record of the chest X-ray that was initially

Documenting details

seems much more of a chore than it really is. When no comment appears in the record of the chest X-ray that was initially taken, one wonders whether the physician looked at it at all.

taken, one wonders whether the physician looked at it at all. He seemed to readily pick up some abnormality after the patient had returned for the physical "under his plan." At this point he contacted the consultant, gave the patient the film and they "discussed in detail the diagnosis." At this point, he obviously looked at the film more carefully. While questions cannot be definitively answered, they are easy to raise and do put the physician in a bad light. The X-ray was taken 18 months before the patient saw the consultant.

The failure to document his impression of the X-ray initially was

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not the only documentation problem faced by the attending physician. There was an entry in the record on seven occasions showing the refill of medications without any suggestion that follow-up was encouraged. After refilling the medications for 18 months, the note appears, "OK, see before more." The supervision of medication by the prescribing physician is an important part of any treatment plan.

Indocin, for example, can produce serious side effects, most commonly relating to the gastrointestinal tract. Ulcerations and bleeding can and do occur. Patients should be watched for occult gastrointestinal bleeding. Tranxene, while a mild tranquilizer, is a mood-altering drug and can be associated with habituation/addiction. The absence of documentation that care is being taken to protect patients from the undesirable side effects of the medications we prescribe helps the plaintiff paint the picture of a physician who is sloppy and uncaring in his approach to his patients, whether that is true.

While the lapse of 18 months during which the diagnosis of cancer of the lung was delayed is probably not ultimately of significance in the usual case of this type, no expert could or would say that such a delay was not important.

For all these reasons, trial was considered out of the question. The case was settled for a six-figure amount. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the April 1999 issue of Tennessee Medicine. It is reprinted with permission.

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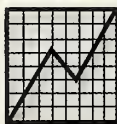
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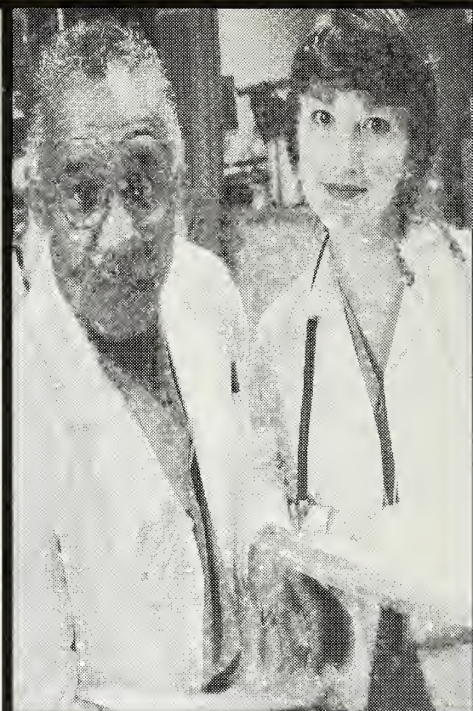
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Influenza Summary Update

During Week 2 (Jan. 9-15), 21% of specimens tested by WHO and NREVSS labs for influenza were positive. State and territorial epidemiologists from 30 states reported widespread influenza activity (Alabama, Arizona, Arkansas, Colorado, Delaware, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia and Washington) and 12 states reported regional activity (Connecticut, Florida, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Montana, New Mexico, Oklahoma and West Virginia).

The proportion of patient visits to sentinel physicians for influenza-like illness was 4% overall in the United States, exceeding baseline levels of 0%-3%, and were above the baseline in six of nine surveillance regions. The proportion of deaths attributed to pneumonia and influenza was 10.5%. This percentage is above the epidemic threshold for Week 2 and is unusually high.

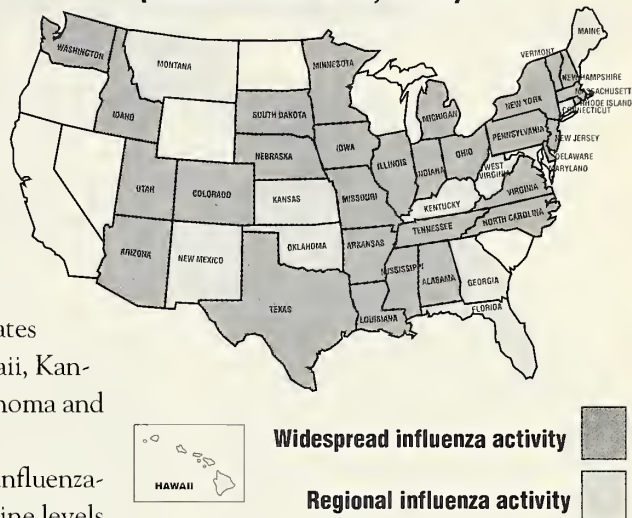
During Week 2, the laboratories tested 2,089 specimens for influenza viruses and 449 (21%) were positive. One hundred twenty-two were influenza A (H3N2) viruses, 318 were untyped influenza A viruses and nine were influenza type B.

From Oct. 3-Jan. 15, 41,034 respiratory specimens were tested for influenza viruses, and 7,361 (18%) were positive. Of the positive results, 7,338 (99.7%) were influenza type A and 23 (0.3%) were influenza type B. Of the 7,338 influenza A viruses, 1,665 (23%) have been subtyped and 1,659 (99.6%) were A (H3N2) and 6 (0.4%) were A (H1N1).

Arkansas has eight counties (Crittenden, Lawrence, Lee, Mississippi, Monroe, Newton, Stone and Yell) that have no reported influenza activity.

Of the reported influenza cases that were either direct antigen positive or culture confirmed, 770 have been type A and five type B (Faulkner, Garland, Ouachita and Washington counties). ■

Influenza Activity (Week of Jan 9-15, 2000)



Reported Cases of Selected Diseases in Arkansas Profile for December 1999 (year-end)

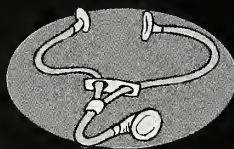
The three-month delay in the disease profile for a given month is designed to minimize any changes that may occur due to the effects of late reporting. The numbers in the table below reflect the actual disease onset date, if known, rather than the date the disease was reported.

Disease Name	Total Reported Cases 1999*	Total Reported Cases 1998	Total Reported Cases 1997
Campylobacteriosis	164	179	175
Giardiasis	149	168	220
Salmonellosis	679	616	445
Shigellosis	75	211	273
Hepatitis A	76	82	223
Hepatitis B	76	115	106
Hepatitis C	8	10	5
Meningococcal Infections	35	31	38
Viral/Aseptic Meningitis	46	77	26
Ehrlichiosis	21	14	22
Lyme Disease	7	8	27
Rocky Mountain Spotted Fever	23	23	31
Tularemia	17	26	24
Measles	5	0	0
Mumps	0	13	3
Chlamydia	5,937	4,127	2,554
Gonorrhea	3,268	3,962	4,388
Syphilis	213	293	396
Pertussis	20	93	60
Tuberculosis	177	171	200

*1999 data are provisional as of 1/24/00

For a complete list of reportable diseases in Arkansas, call the Arkansas Department of Health, Division of Epidemiology, at (501) 661-2893 during normal business hours.

CARDIOLOGY



Raising HDL-C to Prevent Atherosclerotic Events

MARK C. GRANBERRY, PHARM. D. — EUGENE S. SMITH III, MD — J. DAVID TALLEY, MD

Epidemiologic studies demonstrate that serum high-density lipoprotein cholesterol (HDL-C) concentrations are inversely proportional to an individual's risk for atherosclerosis.¹ Based on these observations, the National Cholesterol Treatment Program Adult Treatment Panel II identified low HDL-C concentrations (< 35 mg/dL) as a major risk factor for coronary heart disease (CHD).² While this relationship is well documented, the question remained as to whether interventions that raise a patient's low HDL-C lower the risk for myocardial infarction and other atherosclerotic events.

Patient Presentation

History: A 53-year-old morbidly obese male presented to the hospital with a chief complaint of sub-sternal chest discomfort. He was known to have coronary artery disease and had a myocardial infarction with coronary artery bypass grafting four years previous. Additional diagnoses were systemic arterial hypertension, type 2 diabetes mellitus, hypothyroidism and osteoarthritis (see complete Problem List, Table 1).

Upon admission he was initiated on his home medications which consisted of aspirin 325 mg daily, metoprolol 25 mg twice daily, lisinopril 20 mg daily, isosorbide dinitrate 20 mg 3 times daily, metformin 1,000 mg twice daily (held in anticipation of heart catheterization), glipizide 10 mg twice daily and levothyroxine 100 mcg daily. In addition, a heparin infusion was begun.

Physical Examination: On hospital admission, his pulse was 98 beats/minute, blood pressure was 118/78 mm Hg. His

heart rate was regular without murmurs, rubs or gallops.

Hospital Course: A fasting lipid profile showed a total cholesterol of 128 mg/dL, triglycerides of 257 mg/dL, HDL-C of 25 mg/dL, and low-density lipoprotein cholesterol (LDL-C) of 52 mg/dL. The patient underwent cardiac catheterization which revealed the following coronary artery lesions: left main, 40% distal; left circumflex, 90% mid; left anterior descending, 40% distal; and right coronary, total distal (fills via left to right collaterals). The saphenous vein graft to the ramus and the internal mammary artery graft to left anterior descending were patent. An angioplasty was performed on the left circumflex lesion.

The patient was discharged from the hospital on the medications he was taking prior to admission with the addition of gemfibrozil 600 mg to be taken twice daily. He was to be seen in the cardiology clinic in six weeks.

Discussion

For patients with elevated serum cholesterol, atherosclerotic risk modification should focus on reducing elevated LDL-C.² Several clinical trials show that reducing elevated LDL-C results in lower rates of myocardial infarction, stroke, coronary revascularization procedures and death.^{3,4,5} These trials enrolled hypercholesterolemic patients with mean LDL-C concentrations ranging from 139 mg/dL to 188 mg/dL. However, "normal" LDL cholesterol concentrations are a frequent finding in CHD patients with many of these patients' primary lipid abnormality

being a low HDL-C. One study of 8,500 patients with CAD found that 38% had low HDL-C (< 35 mg/dL) while 17% had isolated low HDL-C (HDL-C < 35 mg/dL together with LDL-C ≤ 130 mg/dL).⁶

Until recently, it was unknown if any intervention targeted at raising low HDL-C concentrations would reduce the occurrence of myocardial infarction or other cardiovascular events. Now the results of two intervention trials, one primary and the other secondary prevention, provide needed information to guide clinicians in their management of these patients.

The first trial supporting the benefit of raising low HDL-C levels comes from the Air Force/Texas Coronary Atherosclerosis Prevention Study (AFCAPS/TexCAPS).⁷ In this placebo-controlled trial, lovastatin 20-40 mg daily was administered to men and women without evidence of CHD, low to normal HDL-C and slightly elevated LDL-C (see table 2 for average lipid concentrations before and after treatment).

By study conclusion, lovastatin had increased HDL-C levels by 6% and lowered LDL-C by 25%. In this relatively low-risk population of individuals, lovastatin reduced the rate of first CHD event (fatal and nonfatal MI, unstable angina, sudden cardiac death) by 37%, however, overall mortality was similar between treatment and placebo groups. Importantly, benefits of therapy were observed predominately for patients whose HDL-C levels were lowest (< 40 mg/dL).⁸

More evidence comes from the Veterans Administration High-Density

**Table 1:
Complete Problem List**

1. Coronary artery disease
 - Etiology** Atherosclerosis
 - Anatomy**
 - a. Coronary artery bypass graft surgery x 2, 1995 reverse saphenous vein graft to ramus intermedius left internal thoracic artery to left anterior descending
 - b. Percutaneous coronary intervention, 1999 to circumflex
 - Physiology** Presentation with acute myocardial infarction
 - Objective** Moderately compromised
 - Subjective** Moderately compromised
2. Systemic arterial hypertension
3. Diabetes mellitus
4. Hypothyroidism
5. Osteoarthritis

Lipoprotein Cholesterol Intervention Trial (VA-HIT).⁹ This trial was conducted to determine if raising HDL-C and lowering triglyceride concentrations would reduce the incidence of death from coronary heart disease and non-fatal myocardial infarction in patients with known coronary heart disease. The study was a double-blind comparison of gemfibrozil 1,200 mg daily versus placebo in men with HDL-C \leq 40 mg/dL, LDL-C \leq 140 mg/dL and triglyceride of 300 mg/dL or less. The median follow-up for 2,531 men was 5.1 years. Average lipid profile values, before and after gemfibrozil treatment, Table 2. Gemfibrozil therapy increased HDL-C by 6% and reduced nonfatal MI and CHD death by 22%. All cause mortality was similar between groups.

In both of these studies, therapy was well tolerated. In VA-HIT, gemfibrozil treated patients had significantly more gastrointestinal complaints than those assigned placebo, but compliance with therapy was unaffected. In AFCAPS/TexCAPS, there were similar rates of serious and minor adverse events in the lovastatin and placebo groups.

Conclusion

A significant number of individuals at risk for CHD have, as their primary

Table 2: Average Lipid Profiles, Before and After Treatment of Patients in VA-HIT and AFCAPS/TexCAPS

	VA-HIT		AFCAPS/TexCAPS	
	Before Treatment	After Treatment	Before Treatment	After Treatment
Total Cholesterol (mg/dL)	175	170	221	184
Triglycerides (mg/dL)	161	115	158	143
HDL-C (mg/dL)	32	34	36	39
LDL-C (mg/dL)	111	113	150	115

HDL-C= High-density lipoprotein cholesterol; LDL-C= Low-density lipoprotein cholesterol
 VA-HIT = Veterans Administration High-Density Lipoprotein Cholesterol Intervention Trial; AFCAPS/TexCAPS = Air Force/Texas Coronary Atherosclerosis Prevention Study

lipid abnormality, low levels of HDL-C without high LDL-C concentrations. While reduction of elevated LDL-C remains the focus for the prevention of atherosclerotic events, for the first time studies have shown benefit for raising low levels of HDL-C. In VA-HIT, gemfibrozil reduced cardiovascular endpoints for patients with low HDL-C and average or below LDL-C levels. The AFCAPS/TexCAPS study showed similar benefit of lovastatin for patients with low HDL-C and slightly elevated LDL-C levels. In both of these trials, small increases (approximately 6%) in HDL-C significantly reduced CHD.

When appropriate, avoidance of drugs that lower HDL-C (e.g. thiazide diuretics, β -adrenergic blockers), diabetes control, and lifestyle modifications such as smoking cessation, weight loss and aerobic exercise can contribute to raising low HDL-C levels. Evidence that drug therapy targeted at raising low HDL-C will reduce myocardial infarction and death due to CHD is now available. Therefore, lipid modifying drug therapies should be individualized to treat low HDL-C when it is the predominant lipid abnormality. ■

Dr. Granberry is with the College of Pharmacy, University of Arkansas for Medical Sciences, Little Rock. Drs. Smith and Talley are from the department of internal medicine and division of cardiology, UAMS Medical Center and the John L. McClellan Memorial Veterans Hospital, Little Rock.

References

1. NIH Consensus Conference. Triglyceride, high-density lipoprotein and coronary heart disease. JAMA

- 1993;269:505-510.
2. Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. Summary of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. JAMA 1993;269:3015-23.
3. Sacks FM, Pfeffer MA, Moye LA et al, for the Cholesterol and Recurrent Events (CARE) Trial Investigators. The effect of pravastatin on coronary events after myocardial infarction in patients with average cholesterol levels. N Engl J Med. 1996;335:1001-1009.
4. Pederson TR, Kjekshus J, Berg K et al, for the Scandinavian Simvastatin Survival Study Group. Randomized trial of cholesterol lowering in 4,444 patients with coronary heart disease: the Scandinavian Simvastatin Survival Study (4S). Lancet 1994; 344: 1383-89.
5. Shepherd J, Cobbe SM, Ford I et al, for the West of Scotland Coronary Prevention Study (WOSCOPS) Group. Prevention of coronary heart disease with pravastatin in men with hypercholesterolemia. N Engl J Med. 1995;333:1301-1307.
6. Rubins HB, Robins SJ, Collins D, et al. Distribution of lipids in 8,500 men with coronary artery disease. Am J Cardiol 1995;75:1196-1201.
7. Downs JR, Clearfield M, Weis S, et al. Primary prevention of acute coronary events with lovastatin in men and women with average cholesterol levels. JAMA 1998;279:1615-1622.
8. Ansell BJ, Watson KE, Fogelman AM. An evidence-based assessment of the NCEP adult treatment panel II.
9. Rubins HB, Robins SJ, Collins D, et al. Gemfibrozil for the secondary prevention of coronary heart disease in men with low levels of high-density lipoprotein cholesterol. N Engl J Med 1999;341:410-418.

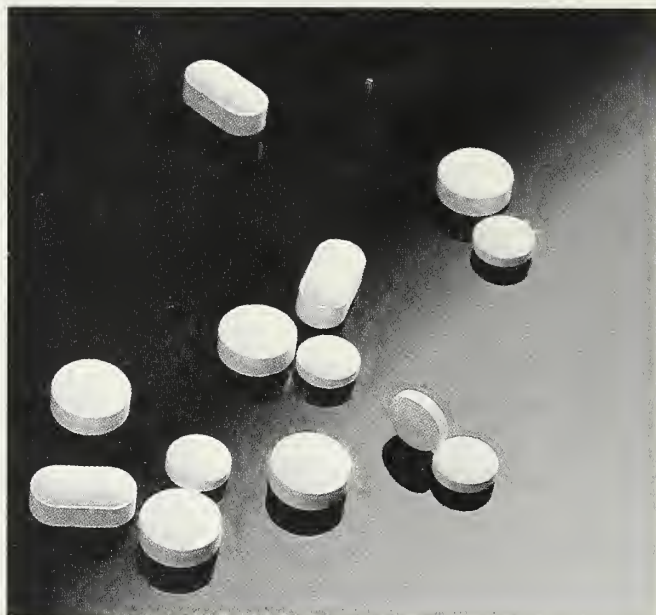
Cholesterol Treatment With Statins and/or Benecol

BY DAVID S. BACHMAN, MD

Cholesterol-lowering drugs, "statins," truly are medical breakthrough agents.

There are no other drugs that have the ability to lower cholesterol levels by as much as 60 points. The drugs function as an inhibitor of HMG-CoA reductase — the rate-limiting enzyme that converts 3-hydroxy-3-methyl-glutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol.

The five brands on the market (Lipitor, Provachol, Zocar, Lescal and ByCol) differ in potency but act in a similar fashion.



The initial fear that these agents cause liver damage has abated. Studies have shown abnormal liver enzymes occur in 1% of patients using the medicine and can be reversed by stopping the drug or sometimes just switching brands.¹

Several large studies have been done. One study demonstrated that some people exhibited elevated liver enzymes when taking "dummy" pills as compared with statin users.¹

An early question pondered by doctors — whether statins not only lowered cholesterol but also decreased risk of heart attack — has been addressed.

Several studies have demonstrated statins — when given to people who have had heart attack or angina — have shown the risk of cardiovascular death decreased 30% after five years of therapy and a 25% to 33% lower risk of heart attack, requiring bypass surgery or angioplasty.^{2,3}

It is anticipated statin use will be broadened when the National Cholesterol Education Program meets this year.

This program, administered by the National Heart, Lung and Blood Institute, has listed the following risk factors for for CHD:

- Male over age 45;
- Female age 55 or older, or premature menopause with out estrogen replacement therapy;
- Family history of premature CHD (definite myocardial infarction or sudden death before age 55);
- In first-degree male relative or before age 65;

- In first-degree female relative;
- Current cigarette smoker;
- Hypertension (blood pressure over 140/90 mmHg or on antihypertensive medication);
- Low HDL cholesterol (<35 mg/dl).

Since 1993, that panel recommended all heart attack patients be placed on a statin if their cholesterol level was mildly elevated. Most doctors now have *all* heart attack patients on a statin — no matter the level of cholesterol. An important question: When should a healthy person be on statins?

A recent study of 6,000 healthy middle-aged men and women with mildly elevated cholesterol levels (above 220) revealed statin use decreased their chance of first-time heart attack by one third.^{1,4}

LDL levels also are being evaluated — present guidelines call for drug use when LDL level is over 160. Many feel that the level should be no higher than 100. Anyone above this level should be on a statin.⁴

The NIH Cholesterol Education Program, administered by the National Heart, Lung and Blood Institute, has revised its guidelines regarding when to start statins.

Risk factors for CHD other than LDL cholesterol:

- Cigarette smoking;
- Hypertension (over 140/90) HDL below 35mg/dl;
- Male over age 45;
- Female over age 65;

- Family history of premature heart disease;
- Premature menopause without estrogen replacement therapy.

For individuals with no coronary heart disease and fewer than two risk factors, drug therapy should be initiated at LDL levels of 190 mg/dl after at least six months of diet and exercise. The goal is to lower LDL to 160 mg/dl.

For individuals with no coronary heart disease but with two or more risk factors and LDL 160 mg/dl, drug therapy, after six months of diet and exercise, should be started and LDL be decreased to 130 mg/dl.

For those with definite CHD or other atherosclerotic disease and LDL 130mg/dl or above, drug therapy should be started after 6-12 weeks of diet — goal for LDL should be 100 mg/dl.

The debate whether to use margarine or butter continues. Transfats (the type of fat formed when vegetable oils are hardened by hydrogenation) should be avoided. Recent studies have shown substituting margarine for butter lowered LDL cholesterol by 5% to 15%.⁵

Not all margarines are the same; some are available without transfatty acids and reduce cholesterol even further. Stick margarine contains more than twice as much trans fat as tub margarine.⁵

For most Americans, fried foods are the greatest source of transfat in their diet. A medium order of fast-food french fries contains four to five times transfat as one tablespoon of stick margarine. The most important consideration for good health should be reducing use of foods made with commercial vegetable shortening. Canola oil and olive oil should be used in cooking.

Despite this success story, only 8 million people are on statins — about half that should be taking it.

Why not more? Many doctors are attuned to crises and not preventive medicine, some doctors are skeptical of statin benefits and undue fear concerning possible liver damage. Some people are deterred by the cost — \$50 to \$100 a month. This is actually a little over the cost of a daily pack of cigarettes. With patent protection loss in two to three years, the price of the drug will come down and generic versions will appear on the market.

Some patients overestimate how much personal control they have over their cholesterol — diet alone will lower cholesterol by 5% to 10%.

There no longer is any question on the

value of statins — the problem is to convince some doctors and patients of their need. There are 39 million people who would benefit from these drugs — their cholesterol levels are over 240. There is a large segment of our population, 98 million, who have moderately elevated cholesterol levels of 200 to 220. This component of the population may well benefit from the use of a new margarine spread, Benecol, a plant statin.^{6,7}

Benecol works by decreasing the absorption of cholesterol from the intestinal tract. There are no side effects, and it can be used by diabetics and patients on a gluten-free diet. This spread, taken as directed (one pad three times a day), has been shown to lower total cholesterol by 10% and LDL by 14%.^{6,7} Those levels lower chances for a heart attack by a third.^{5,6}

This spread is a breakthrough for management of mildly elevated cholesterol and/or LDL levels. In addition to a spread, Benecol is available as salad dressings and soon to be released breakfast bars, yogurt and, later, mayonnaise. It can be used either in conjunction with statin to lower its dosage or possibly replace it once cholesterol levels are corrected.⁷

The monthly cost of Benecol is between \$16 and \$20. Some people feel this is too expensive. Consider the cigarette smoker spending \$3 a pack per day — \$90 a month for a “fix.” The smoker spends money that buys disease whereas a Benecol user spends far less money to buy improved health that lowers risk for cardiovascular disease — a bargain hard to refuse.

Preventive medicine is a tough sell — a person will spend money to prevent their house roof from leaking but ignores abnormal cholesterol levels that may well lead to disease and untimely death. ■

References

1. J.A.M.A. June 16 , 1993 pp 3015-3023.
2. Scandinavian Senvastatin Study.
3. Air Force/Texas Coronary Atherosclerotic Prevention Study 1997.
4. National Education Cholesterol Program Revised 1998.
5. Circulation 1997; 96(12) 4226-4231, Gylling H, Radharhishman R, Miettinen TA.
6. BMJ 1994 308 pp 367-372
7. Medical Science Bulletin Oct 1998.



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Physicians Receive Award from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

Dr. Nick Paslidis of Little Rock has received the award for three years. Dr. Paslidis, whose specialty is internal medicine, also was certified by the American Board of Quality Assurance and Utilization Reward in December 1999.



Nick Paslidis

PRA recipients in November include Dr. Michael Lane Buffington of DeQueen, Dr. Roger Earl Cagle of Paragould, Dr. Scott W. Carle of Little Rock, Dr. Connie Hiers of Jonesboro, Dr. Don Gene Howard of Fordyce and Dr. Randall Evan Hunt of Mountain Home.

PRA recipients in December included Dr. Wayne Patrick Enns of Paris, Dr. Robert E. Holder of Bentonville, Dr. Michael Richard Platt of Gravette and Dr. Priscilla L H Tangunan of Hot Springs National Park.

OBITUARY

Lawrence H. Siegel, MD

Dr. Lawrence H. Siegel, 87, of Fayetteville, died April 18, 1999. A retired urologist, Dr. Siegel is survived by his wife Bobbie. He finished medical school in 1941 and practiced medicine for nearly 50 years.

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The History of Medicine Associates, an organization created to stimulate interest in the history of the health sciences in Arkansas and to promote the collection of the UAMS Library's Historical Research Center, is offering a \$1,000 research award to an individual interested in preparing a paper on any aspect of Arkansas health sciences.

Individuals should make use of the resources in the UAMS Historical Research Center collection when preparing the paper. The award may be used for travel, housing, resource materials and research or secretarial assistance.



There is no required application form.

Applicants should send a proposal (summary) of the paper's topic, a proposed budget and an anticipated completion date to the address given below. **Deadline for applications is May 31**, and the winner will be announced in June.

Send proposals to Edwina Walls Mann, Treasurer, History of Medicine Associates, UAMS Library, 4301 W. Markham St., Slot 586, Little Rock, AR 72205-7199. If you have questions, call 686-6733 or e-mail MannEdwinaWalls@exchange.

uams.edu.

AMA/AHA Coding Workshops

Karen Scott, a certified professional coder from the American Association of Professional Coders, will conduct several daylong workshops across the state on intermediate CPT coding. The workshop is sponsored by the Arkansas Medical Society and the Arkansas Hospital Association. Registration is \$125 for AMS members and staff and \$175 for others. To learn more about the seminar, call Donna Boroughs, Arkansas Hospital Association, (501) 224-7878.

April 11
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April 12
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March 25-28
National Leadership Development Conference

"Is It Good Medicine? A Call to Lead: A Challenge to Serve" is the topic of the National Leadership Development Conference March 25-28 at the Fontainebleau Hilton Hotel in Miami Beach, Fla. The keynote speaker is Tom Peters, acclaimed author of "In Search of Excellence" and "The Circle of Innovation." To register for the NLDC and for additional information, call the American Medical Association's registration

CALENDAR

hot line, (800) 262-3211, or visit the NLDC web site, www.ama-assn.org. To reserve a hotel room, call (800) 548-8886 or (305) 538-2000, or visit the hotel web site, www.hilton.com.

May 4-5 **Antimicrobial Resistance**

The Royal Society of Medicine Foundation, Illinois, and the Royal Society of Medicine, London, have planned a two-day international conference on antimicrobial resistance in Washington, D.C. For more information, contact the Royal Society of Medicine Foundation, (847) 234-6382, fax (847) 234-6511 or e-mail rsmfil@aol.com.

May 12-19 **American Occupational Health Conference**

The American Occupational Health Conference is set for May 12-19 at the Pennsylvania Convention Center in Philadelphia. J.D. Kleinke, MSB, medical economist and author, and

W. Allen Schaffer, MD, senior vice president and chief medical officer of CIGNA HealthCare, are the keynote speakers. The conference serves as the annual meeting for the American College of Occupational and Environmental Medicine and the American Association of Occupational Health Nurses Inc. For more information, contact Debra Bethard-Caplick at ACOEM, (847) 818-1800, ext. 383, or e-mail dcaplick@acoem.org; or contact Yvonne B. Matherne, AAOHN, (770) 455-7757, ext. 110, or e-mail yvonne@aaohn.org.

May 19 **Arkansas Foundation for Medical Care Quarterly Video Conference**

The Arkansas Foundation for Medical Care's quarterly video conference will be from noon-1:30 p.m. at hospitals across the state. For specific loca-

tions, call (501) 649-8501, ext. 203.

June 8-10 **American Board of Medical Specialties Conference**

"Credentialing Physician Specialists: A World Perspective" will be held June 8-10 at the Westin Hotel River North in Chicago. The conference is sponsored by the American Board of Specialties' Research and Education Foundation and the Royal College of Physicians and Surgeons of Canada. Registration fees are \$485, and May 5 is the reservation deadline. For more information about the conference, call the ABMS, (847) 491-9091. To reserve directly with the hotel, call (312) 744-1990.

July 7 **The Royal Society of Medicine**

Fellows and members can join the Royal Society of Medicine for Millennium Member's Day on July 7 in London. The RSM has millennium activities — library competition, library events, oral presentations, sporting events, social events and products — throughout the year. If you're interested in more details about RSM millennium events, contact Kate Lindley, 0171 290 3947 or 020 7290 3947. Keep up to date by visiting the web site at www.royalocmed.ac.uk/2000.htm.



May 5-6, 2000 **Arkansas Medical Society Annual Meeting**

The Arkansas Medical Society will hold its 124th annual meeting May 5-6 at the Embassy Suites Hotel in Little Rock.

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All manuscripts should be submitted to Judy Hicks, Arkansas Medical Society, P.O. Box 55088, Little Rock, Arkansas 72215-5088. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original, one copy and the manuscript on a 3-1/4" diskette should be submitted. Pages should be numbered. Manuscripts and diskettes are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

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- **Nominating Committee Report**

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Volume 96 Number 11
April 2000

THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

Winner of the ASAE Excellence in Communications Award

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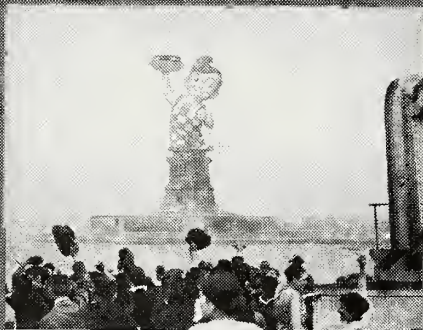
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AMS Goes the Distance for Psychiatrists

By DAVID WROTEN

If something's worth fighting for, you better be ready and willing to go the distance. In February and March 2000, the AMS once again went the distance. The arena was federal district court. The challengers — our state's psychiatrists and the Arkansas Medical Society vs. the Arkansas Department of Human Services.

On Feb. 25, 2000, the AMS filed a motion in federal district court charging DHS with contempt of court for violating a 1994 consent decree that controls physician fees for the Medicaid program. Specifically, the action was in response to a 25% reduction in fees paid to psychiatrists under the new Medicaid mental health managed care program, Behavior Arkansas.

In 1992, the AMS filed suit against DHS over a proposed 20% across-the-board-reduction in physician fees. Because Medicaid fees were already precariously low, the reductions forced many physicians to terminate their participation in the Medicaid program. The AMS asserted that DHS had violated the equal access requirement of federal Medicaid law. This provision requires Medicaid to establish fees at a level that will ensure that Medicaid patients have access to physicians equal to the access afforded privately insured patients.

Judge Susan Webber Wright ruled in favor of the Arkansas Medical Society and the result was a consent decree entered in 1994. The decree initially set Medicaid fees at a level negotiated by the AMS and provides that the AMS must mutually agree to any future changes. Since then, Medicaid fees have remained steady and, together with administrative advancements, have enabled patient access in the program to reach an all-time high.

When DHS first began developing the Behavior Arkansas program, DHS took the position that the consent decree did

not apply since they would be contracting out mental health services to an HMO (ValueOptions) and the HMO would be setting rates. The AMS disagreed and made it clear that any attempt to circumvent the decree would be just cause for filing a motion for contempt. DHS had two choices: Comply with the decree's provisions for making changes or ask the court for a ruling on their assertion that the decree did not apply. DHS did neither.

When it became obvious in February that the program was going to be implemented on March 1 with fees averaging 25% below the approved rates, the AMS was forced to file the motion for contempt. Since Judge Wright retained jurisdiction in the original case, the motion was filed in her court. After hearing more than 12 hours of testimony on Feb. 28 and 29, Judge Wright found DHS in contempt and ordered an injunction requiring DHS to pay the rates approved in the consent decree. To paraphrase the words of Judge Wright, DHS stuck their heads in the sand and went forward knowing full well what the response would be from the Arkansas Medical Society.

Some of the "heroes" willing to go the distance by testifying on the witness stand were Drs. Melanie Risinger from Searcy, Hannah Phillips, Thomas Stinnett, Carlene Lyle, and Charles Gist, all of Little Rock, and Mr. Gary Williams, spouse of Dr. Debra Williams of Pocahontas.

While this recent action involved only psychiatrists, the consent decree applies to all physician services. Dependable reimbursement to physicians, even though it may be relatively low, is a key factor in ensuring that Medicaid patients have access to needed medical services. Certainly, that is something worth fighting for. ■

2000 & BEYOND

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May 6
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- House of Delegates
- Shuffield Luncheon
- Hospitality Hour
- Inaugural Banquet
- President's Reception

AMS Alliance Meeting

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Alliance Board Meeting

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and Installation

Open to AMS members,
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Contact the Arkansas Medical Society at (501) 224-8967 or (800) 542-1058 for registration information.

Report of the Arkansas Medical Society Council

The Council of the Arkansas Medical Society met on April 29, 1999, August 15, 1999, and November 7, 1999. A brief summary of actions taken follows:

April 29, 1999

1. Discussed a letter drafted by the AMA warning physicians of the potential harm that might result if Congress enacts Y2K legislation.
2. Reviewed the AMA's Principles of Medical Ethics that represent the fundamental ethical precepts of medical practice.
3. Procedures for suspending or terminating an Arkansas Medical Society member were presented for approval. Voted to refer this draft to the Bylaws Committee to 1) evaluate the need for the document; 2) make corrections in wording; and 3) clarify the document and to report back to the Council at a future meeting.
4. The Council approved dues exemption requests from component societies.
5. Discussed problems the AMS has experienced with appointments to the Medicare Carrier Advisory Committee and communications with Arkansas Blue Cross and Blue Shield. The Council gave its approval for an ad hoc committee to be appointed to fill vacancies when nominations are not received from the specialty societies.
6. The council made the following appointments:
 - **Budget Committee:** Dr. Anthony Johnson, Little Rock
 - **Journal Editorial Board:** Dr. Jerry Kendall, Camden; and reappointed Dr. Lee Abel, Little Rock
 - **Medical Education Foundation for Arkansas:** Dr. Jan Turley, Rogers
 - Pension Plan:** reappointed Dr. Wayne Elliott, El Dorado
 - **Arkansas Medical Foundation:** Ms. Karen Ballard, Little Rock; and reappointed Dr. John Lynch, Jonesboro
 - **Medicare Carrier Advisory Committee:** reappointed Dr. Kerry Pennington, Warren, representing family practice; reappointed Dr. Samuel Landrum, Fort Smith, representing general surgery; Dr. John Bayliss, Little Rock, representing nephrology; reappointed Dr. Robert Porter, Little Rock, representing orthopaedic surgery; Dr. Curtis Patton, Forrest City, representing pediatrics; Dr. Gerald Stolz Jr., Russellville, representing pathology
 - **Medical Student Councilor:** Ms. Karen McNiece, Little Rock
 - **Arkansas Health Care Access Foundation Medical Student Member:** Twyla Norsworthy, Benton
7. Approved Dr. Tom Eans of Little Rock to fill the Councilor vacancy in the eighth district.
8. Ken LaMastus discussed Wal-Mart had hired a company to seek refunds on claims they felt were an over payment and urged physicians to look closely at any

requests they receive from this company.

9. Dr. Joe Thompson from the Arkansas Center for Health Improvement addressed the Council.
10. The membership and budget reports were reviewed.
11. Dr. William Jones reported on an AMA meeting he attended regarding using tobacco settlement dollars as it relates to Arkansas.
12. Dr. Jones discussed membership and urged the Council to follow through with requests from staff to contact other physicians regarding Arkansas Medical Society membership.
13. Discussed procedures of the House of Delegates and Reference committees.

August 15, 1999

1. Gail Young, president of the Arkansas Medical Society Alliance, asked Councilors to encourage their spouses to join the Alliance and participate in its activities.
2. Dr. John Burge reported on the June AMA meeting including two issues: 1) the sale of products from physicians' offices, and 2) collective bargaining.
3. Discussed legislative issues including the Campbell Bill, an act to allow self-employed physicians to join together to negotiate with health plans.
4. Voted on the AMS position regarding tobacco settlement money. The Arkansas Medical Society believes the number one spending priority should be fully funding the comprehensive tobacco control program developed by the Centers for Disease Control; the Arkansas Department of Health is best positioned to implement the CDC program; and settlement funds should be utilized to secure federal matching Medicaid money to develop an adult program similar to ARKids First.
5. Drs. Kenneth Seiter of Fort Smith and William Galloway of Russellville were approved to fill Councilor positions in the tenth district.
6. Discussed the July conference call of the Pension Plan Committee.
7. Approved the document entitled, "Procedures for Suspension or Termination of Membership in the Arkansas Medical Society."
8. Received an update on the Medical Student Mentoring Program.
9. Approved up to \$10,000 for expenditures for the Long Range Planning Committee pending Budget Committee approval.
10. Dr. I. Dodd Wilson gave an update on activities of the University of Arkansas College of Medicine.
11. Dr. Michael Moody reported the Arkansas Foundation for Medical Care under HCFA direction will review charts for medical necessity and DRG charges.
12. Discussed the Medicaid review process in which the Arkansas Medical Society's Executive Committee participates.

13. Heard a report that pathologists in Arkansas will begin using the Automated Pap Smear System that was approved by the FDA.
14. Discussed the possibility that the Arkansas Medical Society consider providing updates (possibly in *The Journal*) on fraud and abuse cases in Arkansas.

November 7, 1999

1. The council voted for the Arkansas Medical Society to continue discussions with UAMS, Arkansas Department of Health and the Arkansas Hospital Association on how the funds from the tobacco lawsuit settlement should be used. If the AMS staff determines an agreement needs to be reached, it should be presented to the Executive Committee for approval.
2. Discussed the Accreditation Council for Continuing Medical Education's new accreditation system and proposed accreditation criteria for CME sponsors. The council adopted the accreditation criteria.
3. Reviewed an update on AMS Benefits and the upcoming rate increases for clinics covered under the health plan.
4. The following medical student appointments were made:
 - **Ad hoc Committee to Review the Bylaws:** Mr. Justin White
 - **Annual Session Committee:** Mr. Lance Henry
 - **Continuing Medical Education Accreditation Committee:** Ms. Anupama Athota
 - **MEFFA Board of Directors:** Mr. Steven Shrum
 - **Pension Plan Committee:** Mr. Charles Meshek
5. Dr. Scott Ferguson of West Memphis was approved to fill a Councilor vacancy in the first district.
6. Discussed the proposed Insurance Department regulations on prompt payment.
7. Discussed the Arkansas Medical Society's efforts to assist in updating the Workers' Compensation Fee Schedule.



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8. Discussed the termination of 14 Northwest Arkansas physicians by Arkansas Blue Cross and Blue Shield and Mercy Health. Voted for the AMS staff to research this issue and provide a more comprehensive report/recommendation to the Executive Committee.
9. Received an update on the Norwood-Dingell bill that the U. S. Congress passed in October and other legislative issues.
10. Presented the membership and budget reports.

The Executive Committee of the Arkansas Medical Society Council met on May 26, 1999, June 23, 1999, and December 15, 1999. A brief summary of actions taken follows:

May 26, 1999

1. Reviewed evaluations from the Arkansas Medical Society's 1999 Annual Session and discussed next year's program.
2. Discussed the Long-Range Planning Committee.
3. Amended the "Procedures for Suspension or Termination of Membership in the Arkansas Medical Society" and referred the document to the Council.
4. Reviewed a resolution from the Arkansas Hospital Association pertaining to the use of tobacco funds.
5. Discussed physician identification numbers for prescriptions.
6. Approved a listing of physicians requesting direct membership in the AMS.
7. An article entitled, "Doctor's Orders: Medical Lobby Becomes Power house in Austin" was distributed for information.

June 23, 1999

1. The Executive Committee approved a proposed two-day program for the 2000 Arkansas Medical Society Annual Session. A "Year 2000" theme and topics pertaining to "high tech" were suggested.
2. Reviewed revenue and cost of exhibits for the 1999 annual meeting.
3. An orientation program for new councilors was scheduled.
4. Reviewed information on the Arkansas Medical Society's 401K plan and recommended the AMS Pension Plan Committee review it.
5. A listing of physicians requesting direct membership in the AMS was approved.
6. Discussed a letter from Dr. James Adamson, medical director at Arkansas Blue Cross and Blue Shield, pertaining to the selection of members for the Medicare Carrier Advisory Committee.

December 15, 1999

1. Dr. Martin Eisele discussed moving MEFFA funds to the Arkansas Community Foundation. The Executive Committee voted to commend the MEFFA Board for its work and the frugal way it has managed its funds.
2. Reviewed a report from Dr. James Adamson with Arkansas Blue and Cross Blue Shield pertaining to the selection of members for the Medicare Carrier Advisory Committee.
3. Granted requests for emeritus membership.
4. Approved physicians' requests for direct membership in the AMS.
5. Reported on a meeting with representatives from United Healthcare. A thank you letter will be sent to Dr. Sandra Nichols for the information she provided.
6. Reported on a meeting with Dr. William Golden, principal clinical coordinator for the Arkansas Foundation for Medical Care (AFMC). The Executive Committee recommended that Dr. Golden be invited to the next council meeting.
7. Discussed the tobacco lawsuit settlement.
8. Reported on a meeting with Arkansas Insurance Commissioner Mike Pickens. ■

Report of the Nominating Committee

BY C. REID HENRY JR., MD, CHAIRMAN

The 1999/2000 Nominating Committee members are Drs. J.R. Baker, Anthony Hui, Marion McDaniel, Timothy Webb, Paul Wallick, Paul Wills, Michael Young and Chairman C. Reid Henry Jr. The Nominating Committee would like to present to the Society the following nominees:

President-elect:

Joe Stallings, MD, Jonesboro

Vice President:

Paul Wallick, MD, Monticello

Treasurer:

Reappoint Dwight Williams, MD, Paragould

Secretary:

Reappoint Carlton Chambers, MD, Little Rock

Speaker of the House:

Reappoint Anna Redman, MD, Pine Bluff

Vice Speaker of the House:

Reappoint Kevin Beavers, MD, Russellville

Delegates to the AMA:

Reappoint John Burge, MD, Lake Village

Reappoint William Jones, MD, Little Rock

Alternate Delegates to the AMA:

Reappoint Lloyd Langston, MD, Pine Bluff

Hugh Jackson, MD, Fort Smith

District Councilors:

District 1: Reappoint Roger Cagle, MD, Paragould

District 2: Jim City, MD, Searcy

District 3: Reappoint Parthasarathy Vasudevan, MD, Helena

District 4: Reappoint Harold Wilson, MD, Monticello

District 5: Position Vacant

District 6: Reappoint Samuel Peebles, MD, Nashville

District 7: Reappoint Robert McCrary, MD, Hot Springs

District 8: Reappoint Thomas Eans, MD, Little Rock; reappoint Edward Sær, MD, Little Rock; reappoint John Wilson, MD, Little Rock

District 9: D. Wayne Brooks, MD, Springdale; Thomas Langston, MD, Harrison

District 10: Reappoint Kenneth Seiter, DO, Fort Smith; reappoint William Galloway, MD, Russellville

Medical Student Councilor: Mr. Erik Shultz

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Arkansas Medical Society 2000 Budget

INCOME

Dues:	\$712,667	Rent:	\$54,672
Journal and Directory:	\$10,500	Postage and Communications:	\$30,000
Booth:	\$20,125	Insurance and Bonds:	\$50,300
Annual Session:	\$35,700	Auditing:	\$5,000
AMA Reimbursement:	\$10,000	Council and Executive Committee:	\$4,000
Directory and Miscellaneous:	\$7,300	Journal and Directory Expense:	\$12,000
Interest Income:	\$70,000	Dues and Subscriptions:	\$8,200
Specialty Desk:	\$9,957	Gifts and Contributions:	\$2,500
Continuing Medical Education:	\$13,500	Alliance:	\$8,700
Allocation of G.A. Department:	\$5,000	Legal Services (retainer):	\$27,426
Educational Programs:	\$50,000	Committee/District Meeting:	\$5,000
Legal Guide:	\$25,000	Public Relations:	\$3,000
TOTAL	\$969,749	Miscellaneous Expenses:	\$5,000

EXPENSE

Salaries:	\$318,436	Office Equipment and Furniture:	\$7,000
Travel and Convention:	\$35,000	Continuing Medical Education:	\$10,000
AMA Delegation:	\$27,000	Contract Labor:	\$5,000
President's Account:	\$5,000	Winter Meeting:	\$6,500
Taxes:	\$27,400	AMS Resident and Student Section:	\$6,000
Retirement:	\$35,000	Annual Session:	\$57,425
Stationery and Printing:	\$18,000	Educational Programs:	\$29,000
Office Supplies and Expenses:	\$37,000	Physicians Health Committee:	\$10,000
Telephone:	\$10,000	MEFFA — Dues:	\$11,957
		Legal Guide:	\$4,000
		TOTAL	\$875,516

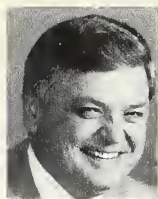
Governmental Affairs Department

INCOME

Dues:	\$239,150	Office Supply, Telephone, Etc.:	\$5,800
Income — Misc. Projects:	\$4,000	Equipment and Furniture:	\$1,500
TOTAL	\$243,150	Auto, Travel and Meeting:	\$50,000

EXPENSE

Salaries:	\$132,618	Legal Retainer:	\$18,300
Retirement:	\$15,000	Postage and Communications:	\$4,000
Taxes:	\$9,700	Insurance and Bonds:	\$7,650
Stationery and Printing:	\$4,000	Office Allocation To AMS:	\$5,000
		Audit GA:	\$1,500
		TOTAL	\$255,068



Report of the Executive Vice President

BY KEN LAMASTUS, CAE

We survived the Y2K problem — the lights came on, and the world economy did not crash. However, many physicians in Arkansas have experienced problems during the past year. The Arkansas Medical Society is continuing to work on some of those problems, but others can only be solved in Washington, D.C.

One problem physicians are facing is that insurance companies and large self-insured cannot be held liable for their actions even if their decisions harm a patient because of an ERISA exemption. Only an act of Congress can solve this problem.

The Patient Protection Act which would hold insurance plans accountable for their medical decision making passed the House side of Congress a few months ago. A different insurance company-favored version passed the Senate. The legislation was referred to a Conference Committee, but the Republican Speaker of the House has refused to appoint any representatives to that committee who favor the Patient Protection Act. This does not bode well for the legislation. In addition, efforts to pass "any willing provider" legislation in Arkansas were quelled last year by the state Senate.

On the state level, managed care is still one of physicians' biggest headaches because reimbursement levels have dropped and expenses have increased. Patients who are being told which physicians they can see and what hospitals to utilize are becoming upset. The public is concerned that physicians are cowering down to insurance companies when it comes to cost containment. They fear they are not getting the most optimum treatment that their physicians want them to have. Fortunately, blame is being placed on managed care orga-

nizations instead of on physicians. It is extremely important now, more than ever, that physicians maintain their role as a patient's advocate.

Slow Payment Concerns

We are continuing to receive complaints concerning slow payments from insurance companies and third party administrators for self-insured. The situation creates cash flow problems for practices. The AMS has met several times with Arkansas Insurance Commissioner Mike Pickens regarding the issue. Also the commissioner has established a committee to review the issue and has promulgated a new rule for prompt payment. An AMS staff person is serving on the committee. The commissioner still refuses to receive complaints from individual physicians because he does not have enough staff.

Tobacco Money Goals

The society continues to work on the tobacco money goals established by the AMS Council. The No. 1 priority should be for tobacco prevention, control and cessation. The No. 2 goal is for Medicaid expansion. Several meetings are being held across the state to gain legislative support to prompt Gov. Mike Huckabee to call a special legislative session to appropriate the money. AMS staff is working in these efforts.

Workers' Compensation

David Wroten, AMS assistant executive vice president, has been actively working with the Arkansas Workers' Compensation Commission to increase the fee schedule, as an improvement is long overdue.

Long-range Plans

Dr. Lloyd Langston, AMS presi-

dent, intends to establish a long-range plan. Dr. Carlton Chambers has been appointed chairman of this committee, and several meetings have already taken place. A large number of physicians from across the state have volunteered their time and input into the long-range planning process. Work is now going on to complete the long-range plan, and it should be ready to be presented to AMS members at the 2000 annual meeting in May. The world is changing, and the society must change with it.

Valuable input was provided by many of the physicians participating in the long-range planning meetings. It was obvious from the participating physicians that they are not aware of the many things the AMS is currently doing. One of the concerns voiced in the meetings was the lack of communication between the AMS and its members. The leading concern is that the society is not adequately using the Internet for communication. To alleviate this problem, the society is checking into updating its Internet system in order to provide better communication with this medium.

Doctors' Involvement

I would like to thank the leadership of the society and the physicians from across the state who participated in the planning process for their valuable input. The doctors elected and appointed to various leadership positions donate a great deal of valuable time in activities that benefit physicians and their patients and contribute to the well being of all the people of our state. I also would like to thank the AMS staff — work at the AMS office could not go on without good employees. We should all say thank you. ■

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Report of the AMS Medical Student Section

By ERIC P. SHULTZ, PRESIDENT

As a reward for
our recruitment
efforts, the
AMA sent our
AMS-MSS
chapter a
check for
approximately
\$3,000, which
will be used for
development
efforts such as
attendance at
sectional and
national
meetings,
recruitment
and support of
local charities.

It is my distinct pleasure to update you regarding the activities of the Medical Student Section of the Arkansas Medical Society and the American Medical Association. 1999 was an excellent year for us in many respects. In the areas of state and national membership, the number of student members increased to more than 85% of all medical students. This membership increase has placed us in a good position to serve others and communicate the virtues of organized medicine. As a reward for our recruitment efforts, the AMA sent our AMS-MSS chapter a check for approximately \$3,000, which will be used for development efforts such as attendance at sectional and national meetings, recruitment and support of local charities.

In the area of local meetings, the student executive council focused on topics that would facilitate both renewed interest and understanding about local and national issues. Our first meeting last spring consisted of a panel of fourth-year medical students, who were matched in various specialties and advised underclassmen about interviewing and other challenges associated with obtaining residency positions. In addition, we held meetings pertaining to medicine and law, financial aid and the importance of student involvement as it relates to our future roles as physicians within the AMS and AMA. With an average attendance of 120 students, all of the meetings were a success.

In the area of national meetings, April Davidson, secretary-treasurer of AMS-MSS, and I were privileged to rep-

resent Arkansas at the AMA's national meeting, held in Chicago in June 1999. Dwight Johnson, vice president of the AMS-MSS, and I were very pleased to be chosen as the representatives for the interim meeting, held in San Diego in December 1999. Charles Meshek and Tom VanHook, both of whom held national positions, as well as Heather Deimer and April Davidson, were also in attendance. We all learned a significant amount of information about the inner workings of the AMA and how it is able to serve medical students from the first day of gross anatomy through our days as practicing physicians.

In the area of projects, several new ideas have been proposed and implemented, including a faculty-student volleyball game and an annual book sale. Through fund raising and other various projects, we were able to make a contribution to the Arkansas Battered Women's Society, a cause we intend to continue supporting. Additionally, the most exciting project, in which many of you are involved, is the Mentoring Program, which is in its first year and has been a great success, according to student feedback. There is still work to be done, but, with continued efforts, this will be one of the most promising endeavors to facilitate student and medical society member interaction. Future projects include a residency fair at UAMS.

I look forward to what next year brings for our medical student section of the AMS. Thank you for your continued support. ■

Arkansas Department of Health 1999 Highlights

By FAY BOOZMAN, MD, DIRECTOR, AND MIKE HUCKABEE, GOVERNOR

As we enter a new era of changes in health needs and health care delivery, there are some obvious principles that we must hold to if we are to improve the health of Arkansans. We must strive for a public health system that emphasizes prevention, has the ability to document and recognize the warning signs of health threats and has the capacity to respond quickly and effectively. The following report highlights our efforts to support that important principle.

In 1999, the Arkansas Department of Health:

- Piloted the Hometown Health Improvement Project in Boone County and expanded the project into Union, Scott, Pike, Polk, Baxter, Montgomery and Washington counties; formed a coalition at each site to address its unique health needs; and also worked with the community health centers to form the Partnership for Healthy Hometowns.
- Developed a statewide infant mortality review process and designed curriculum and provided bereavement training for participants.
- Conducted a folic acid awareness campaign with Arkansas Children's Hospital, the March of Dimes and other providers.
- Created the Arkansas Prenatal and Early Childhood Nurse Home Visitation Program to improve teen-age prenatal health and pregnancy outcomes.
- Aired "The Future is Yours," a teen pregnancy prevention television/radio campaign.
- Implemented measles, mumps and rubella, or MMR, vaccinations in selected occupational sites.
- Responded to the legislature's mandate for an "Arkansas Comprehensive Child and Adolescent Nutrition Policy" by forming a group to study and make recommendations concerning obesity.
- Hosted statewide satellite conferences for health professionals concerning pediatric growth chart development, use and interpretation.
- Formed a partnership with Little Rock's Martin Luther King Jr. Interdistrict Magnet Elementary School and public/private organizations to promote good nutrition and physical fitness in response to an increase in diabetes in overweight children.
- Piloted tuberculosis screenings of foreign-born college students.
- Conducted a statewide seminar to inform mammography technologists about the final regulations for the Mammography Quality Standards Act.

Selected Statistical Indicators

Maternal and Child Health

Child Health Patients	30,163
EPSDT Screening	25,912
Family Planning Patients	83,514
Maternity Patients	16,932
WIC Clients	101,626

Communicable Disease Control

AIDS Testing/Counseling	78,595
TB Skin Tests	99,676

Immunizations

HIB	104,270
Polio	60,908
DTP	137,306
TD (Adult)	38,327
MMR	99,881
DT (Pediatric)	431
EIPV (Salk)	51,261
Hep B	167,486
Varicella	38,961

Breast and Cervical Cancer Control

Screening Mammograms	5,065
Screening Pap Smears	2,114

In-Home Services

Patient Admissions	29,656
Recovering Patient Visits	306,426
Chronic Patient Visits	103,524
Frail Patient Hours	1,524,013
Hospice Patient Days	35,203

Substance Abuse Treatment

Adults Served	12,936
Adolescents Served	401
Regional Alcohol and Drug Detoxification (RADD) Patients	2,584

Laboratory Sample Analyses

.....	438,760
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- Implemented the Consumer-Patient Radiation Health and Safety Act and conducted the initial meeting of the Medical Ionizing Radiation Licensure Committee to develop the Radiologic Technologist Licensure Program.

- Licensed the first Gamma Knife Unit at the University of Arkansas for Medical Sciences to treat inoperable brain cancer and brain function disorders.
- Established an Office of Resource Development to explore potential new funding opportunities.
- Published the first edition of *Diabetes News* to enhance communication between the public and private sectors.
- Administered the first Arkansas Youth Tobacco Survey.
- Participated in developing "The Resource Guide: Assisting Victims of Family Violence," which provides indicators of family violence and suggests questions and appropriate responses.
- Implemented EIA testing for measles IgM and rubella IgM and IgG.
- Collaborated with Recovery Centers of Arkansas' Greater Assistance to those In Need Inc., also known as GAIN, to offer substance abuse treatment, mental health services, housing and job placement for people who suffer from mental illness and substance abuse.
- Presented, by satellite down link, two Harvard School of Public Health violence prevention forums for community leaders.
- Established the Delta Diabetes Council in southeast Arkansas with the American Diabetes Association.
- Established a centralized AIDS Drug Assistance Program to reduce drug costs for treating patients with HIV.
- Established partnerships with area providers and agencies to develop a statewide influenza emergency plan.
- Conducted quarterly private-providers meetings to address HIV-related topics.
- Received a Centers for Disease Control and Prevention grant to work with Little Rock Veterans Administration Medical Center to conduct spoligotyping studies on mycobacterium tuberculosis isolates.
- Received a CDC grant to establish a state clinical laboratory network.
- Approved funding through the State Health Building/Local Grant Trust Fund to renovate the health unit in DeQueen and to construct units in Van Buren, Beebe and Hampton. Received community development block grant funds to construct a unit in Dumas.
- Received a CDC grant to assess the department's ability to respond to a chemical or bioterroristic event. ■

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Arkansas Health Care Access Foundation Inc.

BY MICHAEL C. YOUNG, MD, PRESIDENT, AND PAT KELLER, LSW, CVM, PROGRAM DIRECTOR

As a family practice physician in rural Arkansas, it is my privilege to serve as president of the Arkansas Health Care Access Foundation Inc., or AHCAF, in the year 2000.

I consider it an honor to represent, as well as participate, in the foundation.

I hope this year

"compassion in helping others"

becomes a goal we continue

to meet as we give of our

gifts to others.

AHCAF was begun

with the hope

of making a difference in the lives of the medically needy. Because of the help and compassion of many Arkansas physicians and medical professionals during the last nine years, the progress of this organization has been extraordinary.

AHCAF and its dedicated professionals are committed to providing for the medical needs of many of the 200,000 uninsured, low-income Arkansans. Because of the expansion of the program, eligible Arkansans may have a variety of their needs met, including medical visits, prescription assistance and dental care.

In 1997, AHCAF established the Donated Dental Services Program to provide one-time comprehensive dental treatment to disabled, elderly or medically compromised Arkansans. Volunteer dentists, oral surgeons and dental laboratories donate their treatment to qualified Arkansans. This very popular program has received more than 800 qualified applications since its inception. This past

year, treatment was completed on 70 patients with donated services totaling more than \$88,600.

AHCAF is currently offering medical services to approximately 4,000 active applicants at an annual cost of \$20 per person. The program has served 60,000 Arkansans since its beginning. The most frequently utilized service is physician office visits. Ancillary services include dental visits, free and discounted prescriptions, hospitalization/out-patient services, home health care and access to podiatrists. In 1999, the foundation processed more than 12,000 telephone calls and documented more than 2,000 referrals. Additional visits and services are provided by the volunteers at their own discretion but are not tracked by the foundation.

The support of professional associations and societies representing the medical professions involved with the program is crucial to the program's continued success. We are grateful to the Arkansas Medical Society for its in-kind support and assistance; the Arkansas Hospital Association; the Arkansas Pharmacists' Association; the Home Care Association of Arkansas; the Arkansas Podiatric Medical Association; and the Arkansas State Dental Association for believing in AHCAF.

We offer our profound thanks to the Arkansas Department of Human Services for financial support of the program and the local DHS county offices for staff support in screening the majority of participants. AHCAF could not function without the invaluable assistance of these agencies, which help link individuals with our service.

The foundation continues its longstanding cooperation with the

Arkansas Department of Health by providing treatment resources for patients participating in several ADH programs, including the Breast and Cervical Cancer Control Program, and those needing follow up for suspicious Pap smears. The county health units serve as a point of entry into the AHCAF program by screening applicants who are enrolled in their Department of Health programs.

This year we published our first newsletter, thanks to a donation of \$1,000 by SmithKline Beecham Pharmaceuticals. We continue to receive occasional small donations to the Tom Tapp Fund, which is used to purchase necessary medicines that are not affordable to certain patients.

AHCAF has collaborated with several faith-based volunteer community health clinics in order to reach more Arkansans and has assisted those patients in securing additional medical care. AHCAF staff also are re-educating physicians who work with the community health clinics within the state. Collaboration with other programs will be a priority in the following months.

We remain especially thankful to the volunteer board and the AHCAF volunteer professionals for their untiring commitment and gifts of time and energy.

If you are not involved with the Arkansas Health Care Access Foundation, please consider becoming a volunteer for a program that is sponsored by the Arkansas Medical Society. Your gift of compassion will be a blessing for someone less fortunate. If you wish to know more, please call me at (870) 887-6651 or Pat Keller at (501) 221-3033 or (800) 950-8233. ■

1999 Annual Report of the Arkansas State Medical Board

Including Statistics, Proceedings, Regulations and Amendments

The 1999 members and officers of the Arkansas State Medical Board are as follows: W. Ray Jouett, MD, chairman; Warren M. Douglas, MD, vice chairman; Alonzo D. Williams Sr., MD, secretary; John B. Currie Sr., treasurer; J.R. Baker, MD; John E. Bell, MD; Sue R. Chambers, MD; Ted J. Feimster,

MD; David C. Jacks, MD; Trent P. Pierce, MD; Orman W. Simmons, MD; C.E. Tommey, MD; and James E. Zini, DO.

The Board met bimonthly and addressed complaints, hearings and other pertinent business affecting health care in the state of Arkansas.

1999 Statistics

1999 Licensing Statistics

Medical Doctors and Doctors	
of Osteopathy Licensed	368
Medical Doctors and Doctors	
of Osteopathy (total)	7,889
Medical Doctors and Doctors	
of Osteopathy (in state)	4,950
Occupational Therapists Licensed	99
Occupational Therapists	915
Occupational Therapist Assistants Licensed	16
Occupational Therapist Assistants	125
Physician Trained Assistants	8
Physician Trained Assistants (total)	45
Respiratory Care Therapists Licensed	126
Respiratory Care Therapists	1,224

Summary of Board Proceedings for 1999

Individual Complaints and Discussions (total)	241
Complaints (including investigations)	136
Discussions	105

Complaint (not including investigations)

Advertising	1
Alcohol/Drugs	1
Billing Discrepancies	7
Communication or Dr./Patient Conflict	28

Data Bank Report	0
Emergency Room Treatment	1
Ethics	4
Office Personnel	3
Falsifying Information	1
Failure to Release Medical Records	4
Miscellaneous	14
Negligence	9
Practicing/Allowing to Practice without a License ...	0
Over Charging	0
Over Prescribing	6
Over Testing	0
Actions Taken by Other States	0
Lack of Physician Response	29
Quality of Care Issue	27
Record Keeping	0
Self Prescribing	0
Sexual Harassment	2

1999 Board Actions

Probation	3
Suspension	4
Suspension (stayed)	1
Revocation	7
Revocation (stayed)	6
Surrendered	3

Regulations Passed by the Board and/or Amended During 1999

Regulation No. 23:

Malpractice Reporting

A.C.A. 17-95-103 requires every physician licensed to practice medicine and surgery in the State of Arkansas to report to the Arkansas State Medical Board within ten days after receipt or notification of any claim or filing of a lawsuit against him charging him with medical malpractice. The Notice from the physician to the Board shall be sent by registered letter upon such forms as may be obtained at the office of the Board.

In addition to completing the form, the physician should attach to the form a copy of the complaint if a lawsuit has been filed against him.

Should a physician fail to comply with the terms of Ark. Code Ann. 17-95-103 and these Rules and Regulations, such a violation shall be cause for revocation, suspension, probation or monetary fine as may be determined by the Board after bringing of formal charges and notifying the physician under the provisions of the Arkansas Medical Practices Act and the Administrative Procedures Act.

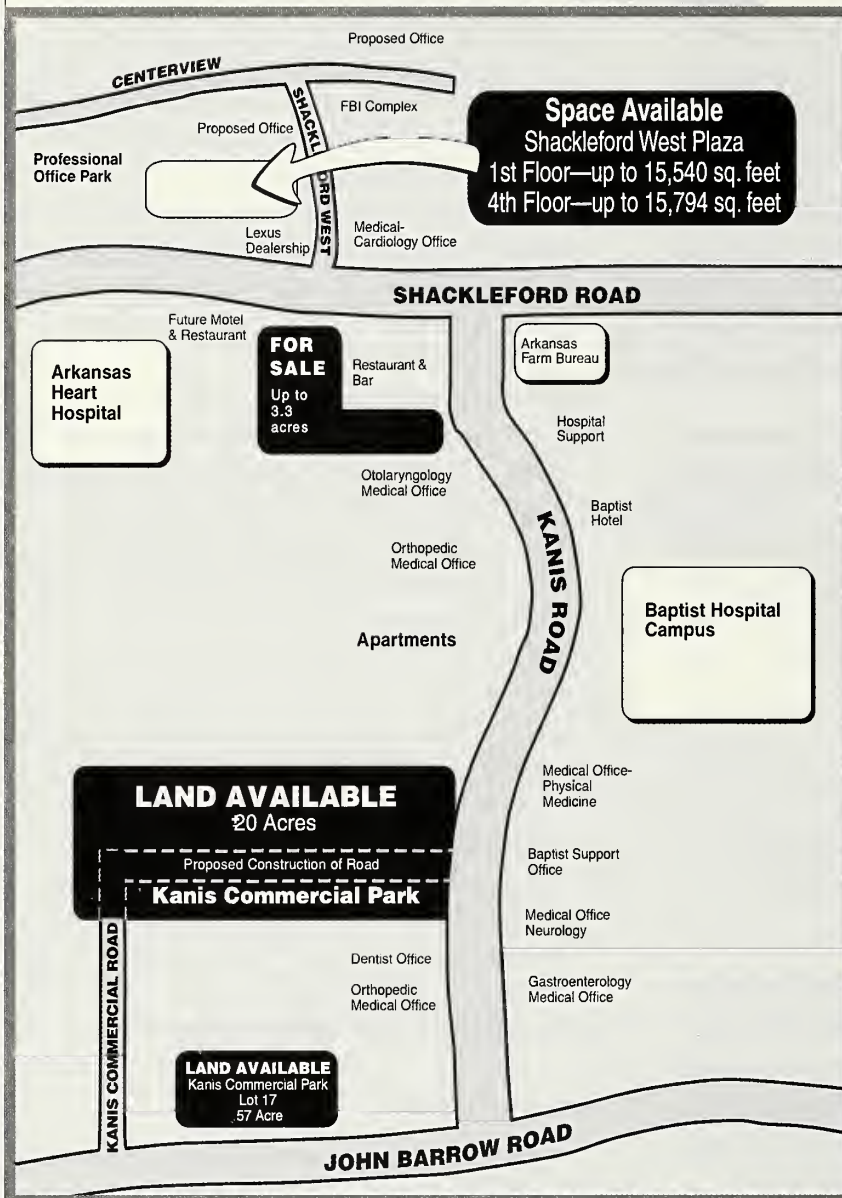
History: Adopted August 12, 1999

Regulation No. 24:

Rules Governing Physician Assistants

1. A physician assistant must possess a license issued by the Arkansas State Medical Board prior to engaging in such occupation.
2. To obtain a license from the Arkansas State Medical Board the physician assistant must do the following:
 - a. Answer all questions to include the providing of all documentation requested on an application form as provided by the Arkansas State Medical Board;
 - b. Pay the required fee for licensure as delineated elsewhere in this regulation;
 - c. Provide proof of successful completion of Physician Assistant National Certifying Examination, as administered by the National Commission on Certification of Physician Assistants;
 - d. Certify and provide such documentation, as the Arkansas State Medical Board should require that the applicant is mentally and physically able to engage safely in the role as a physician assistant;
 - e. Certify that the applicant is not under any current discipline, revocation, suspension or probation or investigation from any other licensing board;
3. (Not yet approved.)
4. The Protocol.
 - a. This protocol is to be completed and signed by the physician assistant and his designated supervising physician. Said protocol will be written in the form issued by the Arkansas State Medical Board. Said protocol must be accepted and approved by the Arkansas State Medical Board prior to licensure of the physician assistant.
 - b. Any change in protocol will be submitted to the Board and approved by the Board prior to any change in the protocol being enacted by the physician assistant.
5. Provide letters of recommendation as to good moral character and quality of practice history;
6. The applicant should be at least 21 years of age;
7. Show proof of graduation with a Bachelor's Degree from an accredited college or university or prior service as a military corpsman;
8. Provide proof of graduation of a physician assistant education program recognized by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.
9. Show successful completion of the Jurisprudence examination as administered by the Arkansas State Medical Board covering the statutes and Rules and Regulations of the Medical Board, the Arkansas Medical Practices Act, the Physician Assistant Act, and the laws and rules governing the writing of prescriptions for legend drugs and scheduled medication;
10. The submission and approval by the Board of a protocol delineating the scope of practice that the physician assistant will engage in, the program of evaluation and supervision by the supervising physician;
11. The receipt and approval by the Arkansas State Medical Board of the supervising physician for the physician assistant on such forms as issued by the Arkansas State Medical Board;
12. Provide proof of medical liability insurance.

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- c. The protocol form provided by the Board and as completed by the physician assistant and the supervising physician will include the following:
 - (1) area or type of practice;
 - (2) location of practice;
 - (3) geographic range of supervising physician;
 - (4) the type and frequency of supervision by the supervising physician;
 - (5) the process of evaluation by the supervising physician;
 - (6) the name of the supervising physician;
 - (7) the qualifications of the supervising physician in the area or type of practice that the physician assistant will be functioning in;
 - (8) the type of drug prescribing authorization delegated to the physician assistant by the supervising physician;
 - (9) the name of the back up supervising physicians and a description of when the back-up supervising physician will be utilized.
5. (Not yet approved.)
6. A supervising physician should be available for immediate telephone contact with the physician assistant any time the physician assistant is rendering services to the public. A supervising physician must be able to reach the location of where the physician assistant is rendering services to the patients within one hour.
7. The supervising physician for a physician assistant must fill out a form provided by the Board prior to him becoming a super-

vising physician. Said supervising physician must provide to the Board his name, business address, licensure, his qualifications in the field of practice in which the physician assistant will be practicing and the name(s) of the physician assistant(s) he intends to supervise.

8. Physician assistants provide medical services to patients in a pre-approved area of medicine. Physician assistants will have to provide medical services to the patients consistent with the standards that a licensed physician would provide to a patient. As such, the physician assistant must comply with the standards of medical care of a licensed physician as stated in the Medical Practices Act, the Rules and Regulations of the Board and the Orders of the Arkansas State Medical Board. A violation of said standards can result in the revocation or suspension of the license when ordered by the Board after disciplinary charges are brought.

9. (Not yet approved.)

10. Continuing Medical Education:

- A physician assistant who holds an active license to practice in the state of Arkansas shall complete 20 credit hours per year of continuing medical education.
- If a person holding an active license as a physician assistant in this state fails to meet the foregoing requirement because of illness, military service, medical or religious missionary activity,

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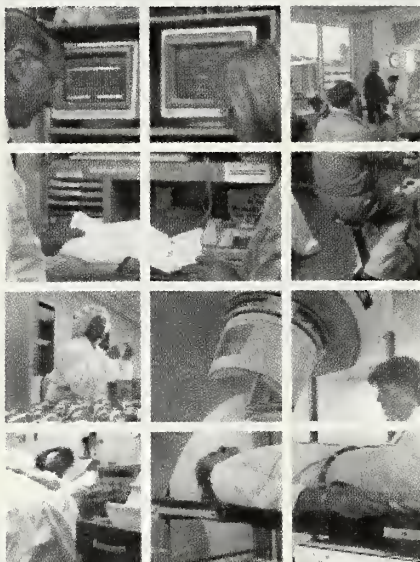
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residence in a foreign country or other extenuating circumstances, the board upon appropriate written application may grant an extension of time to complete the same on an individual basis.

- c. Each year, with the application for renewal of an active license as a physician assistant in this state, the Board will include a form that requires the person holding the license to certify by signature, under penalty of perjury, and disciplined by the Board, that he or she has met the stipulating continuing medical education requirements. In addition, the Board may randomly require physician assistants submitting such a certification to demonstrate, prior to renewal of license, satisfaction of continuing medical education requirements stated in his or her certification.
- d. Continuing medical education records must be kept by the licensee in an orderly manner. All records relative to continuing medical education must be maintained by the licensee for at least three years from the end of the reporting period. The records or copies of the forms must be provided or made available to the Arkansas State Medical Board.
- e. Failure to complete continuing education hours as required or failure to be able to produce records reflecting that one has completed the required minimum medical education hours shall be a violation and may result in the licensee having his license suspended and/or revoked.

History: Adopted October 7, 1999

CME Accreditation Committee Report

By STEVEN STRODE, MD, CHAIRMAN

The Continuing Medical Education Accreditation Committee is charged with the responsibility to accredit intrastate sponsors of continuing medical education, or CME. The committee accredits organizations such as hospitals, not individual CME activities. Among other benefits, accreditation bestows upon an organization the privilege of designating CME activities for the AMA Category 1 credit. Only accredited CME sponsors may designate activities for AMA credit.

During 1999 the committee met in March, August and October. The committee reviewed three of our nine sponsors during 1999 and took the following accreditation actions:

- Baxter County Regional Medical Center — two years full accreditation.
- Washington Regional Medical Center — two years full accreditation.
- North Arkansas Medical Center — two years full accreditation.

Other sponsors are as follows: Baptist Medical Center, Conway Regional Medical Center, National Park Medical Center, St. Joseph's Regional Health Center, St. Vincent Infirmary Medical Center and the VA Medical Center.

CME accreditation is accomplished under the auspices of the Accreditation Council for Continuing Medical Education, or ACCME. The national organization consisting of seven parent organizations—including the American Medical Association and the American Hospital Association—have established a nationwide system of accreditation for sponsors of CME. The ACCME directly accredits sponsors whose scope is national or regional. For intrastate sponsors, the ACCME has established a "recognition" system whereby it recognizes certain organizations, usually state medical societies, to con-

duct the accreditation functions within their state. In 1999, a recognition survey of the AMS was conducted by the ACCME's Committee for Review and Recognition. Satisfactory completion of the survey is a requirement for the AMS to maintain its "recognized" status. Results of the survey have not been received.

The ACCME has adopted a new system of accreditation, System 98, which the AMS also has adopted. The new system was developed with the input of providers and accreditors and will be more user-friendly. Plans are underway to have the new system in place by fall 2000. CME sponsors will be surveyed under the new system beginning in 2001.

Our committee was involved in sponsoring two seminars this year for CME sponsors. We continued our co-sponsorship of the Southeast CME Symposium with the state medical associations of Alabama, Mississippi and Louisiana. The 1999 symposium was held in Point Clear, Ala. In October, we sponsored a 1 1/2-day workshop for Arkansas CME providers in Eureka Springs. This was the third of what we hope will continue to be an annual event.

My report would not be complete without calling your attention to the enormous amount of time and energy expended by the committee members and the AMS staff. For each of the accreditation decisions mentioned above, many hours of preparation is involved in reviewing applications, conducting the mandatory on-site survey of the sponsor and developing the reports and summaries of our findings. In addition, committee members and staff handled countless inquiries from sponsors and prospective sponsors, often necessitating on-site consults at locations around the state. Many thanks to these volunteers. ■

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Medical Education Foundation for Arkansas Report

BY MARTIN EISELE, MD, PRESIDENT

The Medical Education Foundation for Arkansas was organized by the Arkansas Medical Society in 1959. Members of the board are Drs. William Bishop, Little Rock; James Kyser, Little Rock; Jan Turley, Rogers; and Mr. Steve Shrum, medical student representative. Serving as ex-officio with voting power are the Arkansas Medical Society president, president-elect, immediate past president and the dean of the University of Arkansas College of Medicine.

The Foundation receives funds contributed by the Arkansas Medical Society that amounts to \$5 for each full dues paying member per year. Since MEFFA is a tax exempt (501(c)(3) Foundation, all contributions are tax deductible. By conservative investment and expenditures, the Foundation has grown to a net worth in excess of \$650,000. The Foundation has an in-

dependent audit each year and a copy of the audit is provided to the Council. Funds are used each year to promote the art and science of medicine and the betterment of the health of the public by providing financial support to recognize schools or institutions that provide primary and advanced medical education. The Board has established a policy of accumulating funds over a period of time so that in the future the Foundation will have adequate funds to undertake major projects.

During 1999 the Foundation made the following contributions to the University of Arkansas College of Medicine:

- \$21,150 for equipment to be used for medical student education.
- \$8,000 to the UAMS Distinguished Lecture Series (10 lectures at \$800 each).
- \$5,000 to the Ben Saltzman En-

dowed Chair in Rural Family Medicine.

- \$2,000 to the History of Medicine Associates.

The MEFFA Board also approved establishing a 170 Plan, or planned giving plan. The program accepts contributions from physicians. The contributions are used to purchase lifetime annuities. At retirement, physicians and their beneficiary may draw from the annuity. At their death, the proceeds of the life insurance less 10% is paid to MEFFA. A portion of the contribution is tax deductible.

In 1999, the MEFFA Board transferred \$578,000 in funds to an account with the Arkansas Community Foundation. Earnings from the fund are still controlled by the MEFFA Board. This avoided future tax liability by MEFFA and will provide a lower investment cost of managing the funds. ■

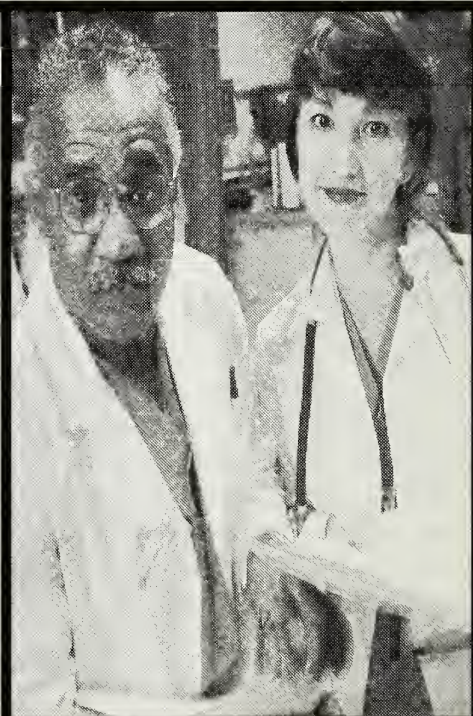
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Arkansas Medical Foundation Report

By JOE L. MARTINDALE, MD, MEDICAL DIRECTOR

The Physicians' Health Committee was formed to intervene, assist and advocate for physicians with substance abuse problems. Funding for the Foundation is provided through an increase in licensure fees of all Arkansas physicians. The Arkansas Medical Foundation is a 501(c)(3) organization. All inquiries, requests for help and assistance provided are considered confidential.

Members of the Arkansas Medical Foundation Board of Directors are Larry Lawson, MD, Paragould, president; Joanna Seibert, MD, Little Rock, vice president; Ms. Karen Ballard, Little Rock, secretary/treasurer; Glen Baker, MD, Little Rock; and John Lynch, DO. Ex-officio members are Ray Jouett, MD, Little Rock, chairman of the Arkansas State Medical Board, and Ken LaMastus, Little Rock, executive vice president of the Arkansas Medical Society. Dr. Glen Baker has completed his term on the board. The board is seeking a replacement for the position and will make a recommendation to the AMS Council at the May meeting.

Activities for 1999 included:

- This year optometrists were added to the monitoring program. Participants in our program now include physicians, licensed respiratory care therapists, dentists, dental hygienists and optometrists.
- Sixty-two physicians and seven dentists, as well as physicians from other states who serve as "locum tenens" in Arkansas, are currently being monitored.
- Six physicians and two dentists have had relapses in the past 3-1/2 years. There has not been a relapse since January 4, 1998. Two of these physicians are no longer practicing medicine, and the other four have successfully completed their treatment for relapse and are currently being monitored by the committee. Both dentists have successfully completed their treatment for relapse and are also being monitored by the committee.
- We continue to work with health maintenance organizations, preferred provider organizations, hospital credentialing committees, malpractice carriers, probationary officers, state medical boards, state monitoring programs, respective Arkansas licensing entities and the DEA to help physicians to continue practicing medicine.
- We have been contacted by various entities with prospective employment opportunities for physicians in emergency rooms, covering clinics when other physicians are on vacation and for recovering physicians to join established practices.
- We have become a directed practice site for students of Arkansas Tech University Health Information Management Program. This allows students to explore other means of non-traditional employment within the medical record field.
- We continue to keep participants informed of continuing medical education courses related to substance abuse, prescription writing, sexual issues, ethics, stress management and other topics of interest.
- We are currently working to establish strong support groups for physicians, their spouses and children. A workshop for spouses was held in March 2000.
- An article about our program was published in the December 1999 issue of *The Journal of the Arkansas Medical Society*. ■

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Report of AMS Benefits Inc.

BY LLOYD LANGSTON, MD, CHAIRMAN OF THE BOARD

Despite the
drastic
changes
in the
group health
insurance
arena, the
health plan
still continues
to grow.
AMS Benefits
has added
159
employees
to the plan
for a net
growth
of 17%.

AMS Benefits Inc. is a for-profit, wholly owned subsidiary of the Arkansas Medical Society. One of the duties of the AMS president is to serve as chairman of the board of directors of AMS Benefits. By issuing an annual report to the AMS House of Delegates, the board hopes to keep the AMS membership apprised of our activities and to remind members of the services available through this organization.

The primary mission of AMS Benefits is to administer and promote AMS sponsored insurance programs. The company is licensed through the Arkansas Insurance Department and has a full-time licensed agent, Alanna Scheffer. Revenue for the company is derived from administering the AMS Health Benefit Plan and by marketing other products to AMS members through Hoffman-Henry Insurance Agency. American Investors Life Insurance Company in Little Rock underwrites the AMS Health Benefit Plan.

Revenue generated by the health plan was more than \$150,000, which represents a 7% increase over the previous year. Revenue generated by the marketing of other products through Hoffman-Henry was \$4,800. Net income for AMS Benefits Inc. on a cash basis was about \$32,000.

Despite the drastic changes in the group health insurance arena, the health plan still continues to grow. AMS Benefits has added 159 employees to the plan for a net growth of 17%. We have 86 clinics insured, representing more than 1,800 lives (employees and dependents). The total annual premium paid during 1999 exceeded \$3 million.

I would like to bring to your attention some recent events with American Investors and the AMS Health Benefit Plan. Because of the impact of new HIPPA regulations and the increased utilization experienced industry-wide, we were subjected to two rate increases in 1999 but still remain competitive and lost only one group during this period.

American Investors recently purchased a new top-of-the-line claims adjudication system to increase productivity and decrease claim turn-around time. Because of complications during the conversion, claim payments have

been seriously delayed for the first time since we contracted with American Investors in 1995. We have been assured by American Investors that once it has cleared out the backlog of claims, it will be within insurance department regulations for timely payment.

In 1998, American Investors began using the CorVel network for its managed-care product. At that time, CorVel continued to maintain a contract with AMCO, which gave our policyholders access to both networks. In January 1999, AMCO gave a one-year notice of termination of its contract with CorVel. CorVel immediately began to try to contract with AMCO providers to provide a continuity of care. At the end of this contract, there were still several hundred providers who had not yet contracted with CorVel; and, therefore, American Investors agreed to pay these providers as if they were in network until they improve the current network. AMS Benefits will be contacting these providers on behalf of our insured members to see if we can encourage them to participate in our plan.

In June 1999, AMS Benefits entered into an agreement with A.F. Smith and Associates and Baird, Kurtz and Dobson to provide a section 419A Plan called the Advantage Plan. The Advantage Plan is an opportunity for AMS members to obtain tax deductions for life insurance premiums on policies that provide estate liquidity or fund buy/sell agreements. Because of possible legislation that would effect this plan, it was not offered to our members until October 1999. Meetings will be held across the state with interested members and their attorneys to discuss the plan's advantages.

After the 2000 AMS Annual Session, your new president, Dr. Gerald Stolz Jr. of Russellville, will assume the position of chairman. I wish to thank the other members of our board and the AMS Benefits staff for their support and hard work. Other board members are Dr. Michael Moody, Dr. Dwight Williams, Dr. Gerald Stolz Jr., AMS Executive Vice President Ken LaMastus, Assistant Executive Vice President David Wroten and AMS Director of Government Affairs Lynn Zeno. ■

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Pulaski County Medical Society

1999 Annual Report

Led by President C. Reid Henry, MD, 1999 was a year of change for the Pulaski County Medical Society. Carolyn Brummett was named executive director, succeeding Fred Reddoch who served the society for more than 11 years.

William N. Jones, MD, assumed a leadership role in drafting and articulating a plan for use of Arkansas' tobacco settlement funds for the improvement of public health. Dr. Jones is a PCMS board member, Councilor to the Arkansas Medical Society and delegate to the American Medical Association.

Membership in the society increased to approximately 1,000 members. Renovation of the society offices, in the Doctors' Building at 500 S. University, began in August.

A Pulaski County Medical Society Student Alliance group formed to address needs of medical students at the University of Arkansas for Medical Sciences. Sophomores Owen Middleton and Heather Diemer led organizational efforts on behalf of UAMS students. Four UAMS students received scholarships through the PCMS.

The Annual Doctor/Lawyer Dinner at The Country Club of Little Rock drew more than 200 physicians, attorneys and guests for an evening of entertainment and friendly roasting. John L. Wilson, MD, represented the physicians.

State Rep. Randy Lavery was guest speaker at the society's annual meeting at the Capital Hotel. The topic was physician involvement in the legislative process. ■

Pulaski County Medical Society Board of Directors

Pulaski County Medical Society Officers

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Anthony D. Johnson	President Elect
David E. Bourne	Vice President
Denise R. Greenwood	Secretary
Steven W. Strode	Treasurer
C. Reid Henry	Immediate Past President

AMS Councilors

Joseph M. Beck III	(Term expires: 2001), E-1992
C. Reid Henry	(Term expires: 2001), E-1997
Anthony D. Johnson	(Term expires: 2001), E-1995
William N. Jones	(Term expires: 2001), E-1992
J. Mayne Parker	(Term expires: 2001), E-1993
Edward H. Saer III	(Term expires: 2000), E-1997
Samuel B. Welch	(Term expires: 2001), E-1996
John L. Wilson	(Term expires: 2000), E-1994
Thomas L. Fans	(Term expires: 2000), E-1999

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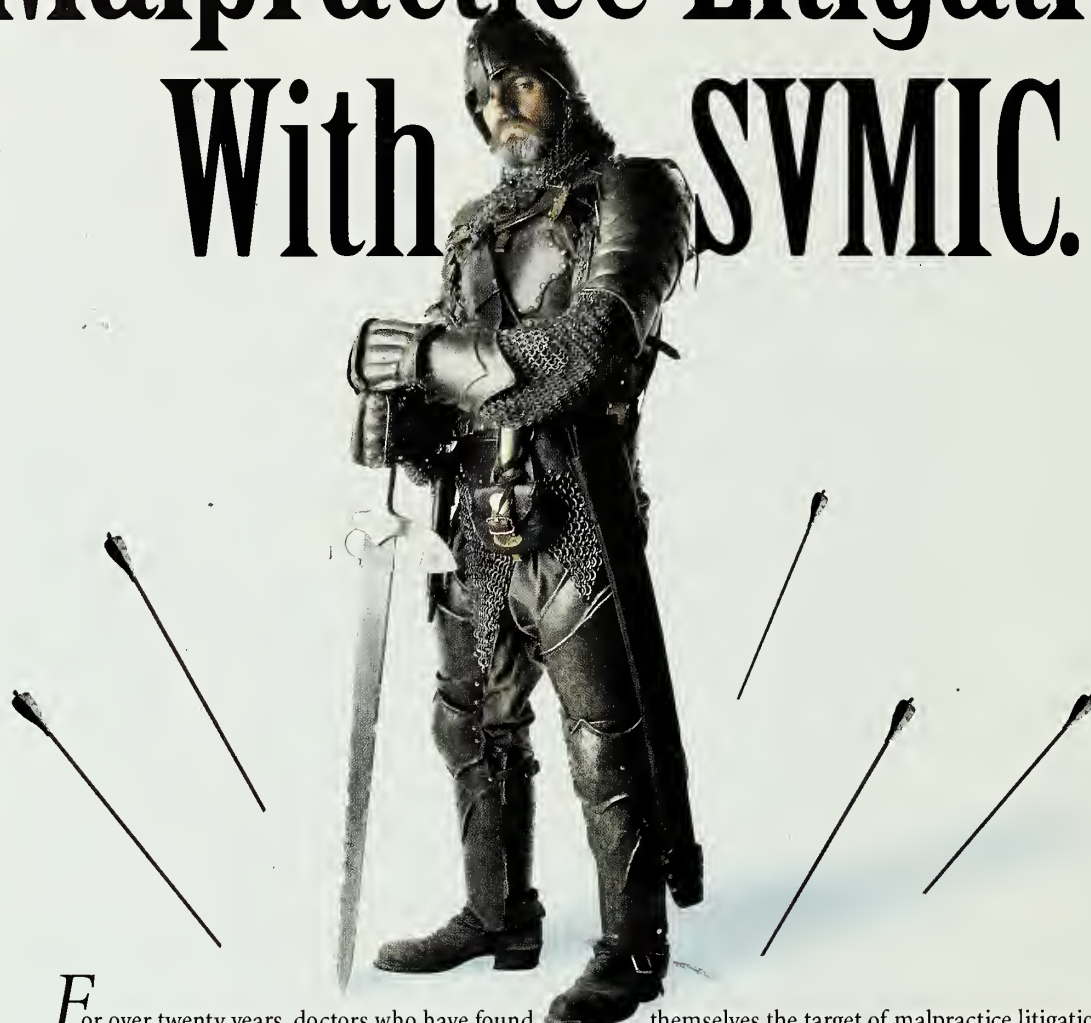
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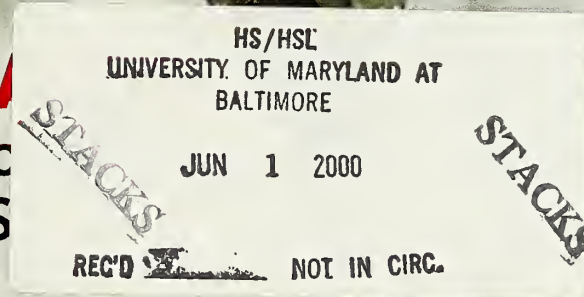
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430 New President Is Ready to Work

Dr. Gerald A. Stolz, a pathologist from Russellville, will take the reins this month as president of the Arkansas Medical Society. Included in his plans for the year are boosting the number of younger physicians in the Society and reaching out to more minority and women physicians.

432 Preventing Payment Errors

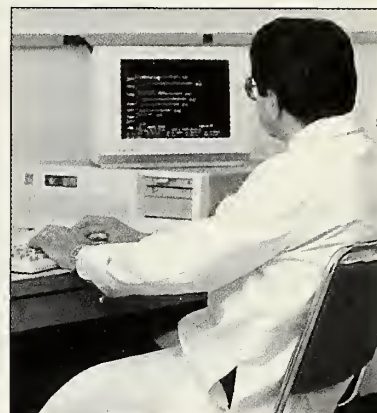
The Health Care Financing Administration has directed the Arkansas Foundation for Medical Care, as well as all peer review organizations nationwide, to initiate a Payment Error Prevention. The goal of the new program is to reduce hospital inpatient payment errors. Physicians play a major role in providing accurate, useful data that can be coded correctly.

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The American Medical Association awarded Little Rock pediatric allergist Dr. Kelsy J. Caplinger one of five Pride in the Profession Awards for his involvement in Medical Camps of Arkansas Inc. Dr. Caplinger founded the MedCamps in 1971, allowing children with chronic illnesses to go to summer camp.

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A study shows rural Arkansas patients are comfortable with computers in the exam room. The study evaluated the acceptance of using computers to take a medical history by rural Arkansas patients. Sex, age, race, education, previous computer experience and owning a computer were used as variables.



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There are Just Too Many Words...

By JERRY D. BYRUM, MD

With all the advancements in communication technology in our society, one would think that the quality of communication in the field of medicine would be at an all-time high.

Advancements such as cellular telephones, paging devices, faxes, e-mail, telephone messaging centers, voice mail, dictaphones, transcription services, voice recognition programs, computers, hand-held devices, printers, electronic medical records and ordering systems, the Internet, web sites and even "snail mail," are all examples of the way we talk to each other today. The volume of communications that we deal with on a daily basis has dramatically increased. However, despite these advances, I am concerned about an area of communication that is vital to the quality of care that we render to our patients. Now I am not saying that we are somehow at a loss for words. It seems that we as physicians have a lot of words to deal with each day. What I am saying is that there seems to be little meaningful communication.

What we really have is noise. In the midst of a busy day, drug company representatives tout their products with verbal claims and counter-claims. These claims are supported with mounds of slick brochures that are quickly filed in the trash. Teleconferences are held where paid physicians inform us of what we should or should not do in our practices. Insurance companies send and receive authorization forms. Therapy, infusion and medical equipment companies send round after round of order sheets asking for diagnosis information and the physician's signature authorizing the treatment or equipment.

The point of these communications is not what is in the best interest of the patients, but rather justifying to an insurance company why a treatment or

procedure should be paid. The pharmacy calls with a prescription refill request. Telephone calls are made asking for permission to treat in the emergency room. Hospital personnel call and are called to discuss various things. The "delete key" on my computer is constantly being pushed to delete all the junk e-mail that I am sent each day. The medical records department informs me that I am on the "bad list." The list of interactions goes on and on.

Despite all the words, in my opinion, one very important type of communication in our profession is diminishing. What I am talking about is physician-to-physician communication. Simply, we as doctors don't talk to each other much anymore. We don't talk about our difficult patients. We don't talk about the interesting cases we have seen or the recent continuing medical education course we attended. We don't discuss the best approach to take in treating a certain disease. Nor do we even talk to our consultants about why we are asking them to see our patients. Most of the time, a consultant has to piece the question of why they are seeing a patient from the chart and or the patient themselves.

I'm not sure why this trend is so. Let me take a guess or two. Maybe it is our so called "post modern" culture in America, where relativism and the pursuit of individuality lead to social isolation and a disconnection from others. Maybe it's because we're just too busy. Or maybe there are only so many words that we can receive and give out each day and that limit is exceeded from all the noise.

The costs of our poor physician-to-physician communication are great. At the least these include subjecting our patients to unnecessary tests and procedures with the attendant increased costs and risks, wasting our consultants

time with diminished efficiency, occasionally possibly missing a diagnosis, delaying treatment, losing educational opportunities for ourselves and losing the collegial spirit, which has helped to make medicine a very gratifying profession of which to be part.

How can we do better? First, let us stop by the physician lounge in the hospital sometime and stay a while. You might be surprised at whom you will meet and what you will learn. Let's communicate with each other down the hall and in the elevator. Learn to acknowledge the presence of other physicians when they are present. Engage them in conversation. A simple, "What do you do?" is a good place to start.

Let us eliminate blocks to communication with each other caused by a good front office telephone defense. This defense sounds something like this, "I'm sorry but Dr. Smith is in a room with a patient. May I have her return your call.?" When a fellow physician calls, let us make time for him or her. I know of one physician who takes this so seriously that he will even take a referring telephone call on the intercom while operating in the operating room. It can be done.

When we consult another physician for an opinion, a test or a procedure, let us communicate the reason we want the consult. This is best done in person or on the phone, but also a letter will do nicely. Consultants, communicate your findings and plans. Let us as Arkansas physicians continue to provide our patients with the best care. This can only be done when we communicate with our colleagues about our patients, our practices and ourselves. ■

Dr. Byrum is a Little Rock pediatrician and a member of the editorial board of The Journal of the Arkansas Medical Society.

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Patient Safety — the Right Prescription

By DAVID WROTEN

Last November, the Institute of Medicine published the much publicized report, "To Err is Human: Building a Safer Health System." The report made national headlines and became the lead story for many television "news" programs.

The findings in the IOM report and similar reports are startling. An estimated 44,000-98,000 people die each year as a result of medical errors. That's more deaths than from motor vehicle accidents, breast cancer and AIDS. Deaths from adverse drug events total more than 7,000 annually. One out of three cases of medical errors causes permanent harm, with half of all errors occurring in hospitals.

Regardless of how you view the validity of these studies, the fact remains that medical errors do occur, and the results are costly, both in terms of human life and the trust that patients place in our health care system. Congress will debate this issue and at some point may even pass legislation requiring voluntary or mandatory reporting systems.

The American Medical Association, American Hospital Association and other professional associations are not content with waiting for someone else to solve this problem. All are working on initiatives to address medical errors from their own perspectives.

In Arkansas, we have the opportunity to lead the way in developing state-level initiatives to improve the safety of our (your) patients. The Arkansas Medical Society has had initial discussions with the Arkansas Foundation for Medical Care and the Arkansas Hospital Association. Additionally, on April 17, Medicaid sponsored a "medication error summit" that brought together the AMS, AHA, Arkansas Pharmacist Association, Arkansas Board of Pharmacy, AFMC, Arkansas Department of Health and other interested stakeholders.

As a result of these two meetings, the AMS has recommended that a task force be established to work with the Arkansas Foundation for Medical Care to develop and implement quality improvement projects aimed at improving patient safety in Arkansas. Initially, the task force will be able to utilize existing data from hospitals, the department of health and the licensing boards to identify the types of errors that occur and then design educational activities or system changes to reduce and prevent future errors from occurring.

We must accept that humans will make errors, even health professionals. Indeed, the tort system (malpractice) and licensing boards were created to provide a remedy for individuals harmed and punishment for those who cause harm. However, it also is true that our systems (of ordering medications, preventing infections, transmitting orders, etc.) can sometimes be the reason that an error is made. If not the cause of the error, then it also is possible that the system sometimes fails to prevent an error from occurring.

The physician's moral and ethical responsibility is to do what is best for his or her patient. I've never met a physician who didn't believe this. It is in keeping with that responsibility that the AMS and its member physicians will accept the challenge to address this important issue. We truly have the opportunity to be on the leading edge of improving patient safety. With the cooperation and support of AFMC and the other professional health care associations, we can and will make a difference. ■

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Meet Our Members

Gerald A. Stolz Jr., MD

BY CHRISTY L. SMITH

Dr. Gerald A. Stolz admits he has an affinity for travel.

Granted, the 55-year-old pathologist from Russellville is referring specifically to spending time with his wife of 35 years, Judy, on Greers Ferry Lake and the southwest Florida island, Captiva.

But Dr. Stolz said he doesn't mind that he will have to increase his travel time between Russellville and the Arkansas Medical Society's headquarters in Little Rock once he is sworn in this month as society president.

In fact, Dr. Stolz already spends much of his time on the road, as he divides his time among Hot Springs, Russellville and eight small communities, including Danville, Ozark and Booneville.

He currently maintains pathology and laboratory services directorships at National Park Medical Center in Hot Springs and AMI-St. Mary's Regional Medical Center,

Millard Henry Clinic and Pathology Services Laboratory, all in Russellville. In addition, he is a consulting pathologist at several small hospitals scattered across the state.

"I spend most of my time at St. Mary's and in Hot Springs. As a consulting pathologist, I make monthly lab visits to the smaller hospitals," he said.

Choosing Medicine

Born in El Dorado to a stay-at-home mother and a father who worked in the oil business, Dr. Stolz says that he has always wanted to be a physician.

"I can't remember a time when I didn't want to be a doctor," he says.

He attended Hendrix College in Conway for three years. The biology major applied for admission to the University of Arkansas for Medical Sciences in Little Rock during his junior year of college and was accepted.

"At that time, the medical school took a limited number of students who had completed three years of college . . . I applied thinking I wouldn't get in, but I did. Then I had a dilemma on my hands — go on to medical school or stay at Hendrix and complete my degree. It didn't take me long to decide I'd better go on to medical school because I might not get in later," he laughed.

Dr. Stolz began his residency in anatomical and clinical pathology at UAMS, but then moved to New Orleans to serve as a resident at USPHS Hospital and Louisiana State University's Charity Hospital for two years.

"I wanted a little bit of variety in my experience, to see a different training program in pathology and gain a different perspective," he said.

Dr. Stolz finished his residency at UAMS in 1973 and moved to Russellville to be director of pathology and laboratory services at St. Mary's Regional Medical Center. He established the clinical Pathology Services Laboratory two years later and remains president and laboratory director, overseeing the work of five pathologists and a full staff of laboratory professionals.

Serving the Profession

Since he began practicing in 1973, Dr. Stolz has taken on a number of other directorships and consultancies, but he says his most important hat to date may be the one he will wear as president of the Arkansas Medical Society during the 2000-2001 term.

Dr. Stolz joined the AMS during his first year of practice and has served the organization in various capacities through the years. For instance, he was a member of the society's committee on hospitals from 1984-1988, a member of the continuing medical education committee from 1988-1994 and a member of the nominating committee from 1993-1996.

In addition, Dr. Stolz has previously served the AMS in two elected offices — 10th District Councilor from 1988-1996 and chairman of the Council from 1996 until 1999.

Dr. Stolz said that as Council chairman, he oversaw the day-to-day activities of the medical society during the time

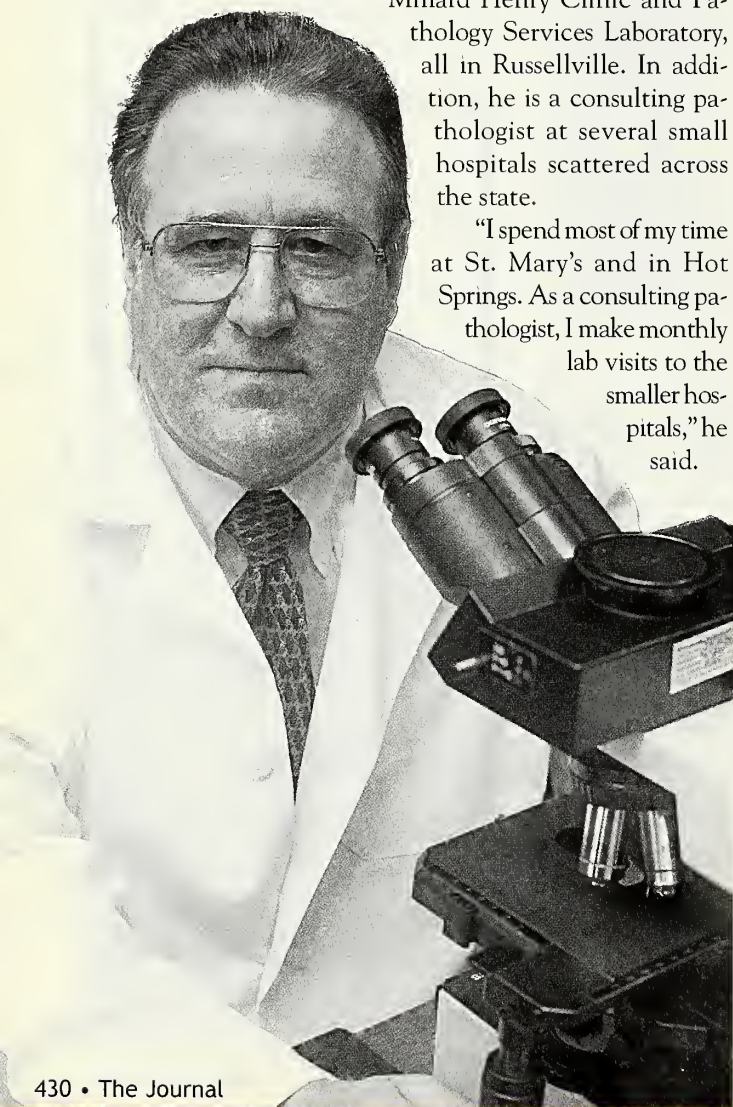


Photo: Kirk Jordan

between council meetings, which are held quarterly.

"It's not a paid position, but it is definitely a working position," he said.

The position required Dr. Stolz to travel often to AMS headquarters in Little Rock, a practice he will continue after being sworn in as president of the society at the annual conference May 6 at the Embassy Suites in Little Rock.

Taking the Helm

When asked what type of president he will be over the course of the next year, Dr. Stolz first points out that there are three kinds of people in this world — those who make things happen, those who watch things happen and those who wonder what happened. He wants to be the type of president who makes things happen, and he wants the AMS membership to share his active attitude, he said.

"I will commit myself to doing the best job possible for physicians in the state of Arkansas and represent their interests as well as I can . . . but I also want Arkansas physicians to be [involved] at the top level, making things happen for the society," he emphasized.

Two of his biggest goals, he says, are addressing the needs of the new physicians who are joining the society's fold and making sure that women and minorities are well represented in the society's ranks.

"I want to definitely continue the work of the strategic planning committee because we are getting more and more younger physicians involved in the Council," he said.

Dr. Stolz said he hopes the older members of the AMS will assist him in encouraging young physicians to join the society rather than letting the new doctors go into practice without becoming involved in an organization that can provide them with much-needed encouragement and support.

"We must respond to the needs of younger physicians; they will determine the future of the society," he said.

Dr. Stolz said that another of his goals is to bring more women and minority doctors into the field.

"Approximately 50 percent of the graduates of medical schools across the United States are now women and minorities. The profession is changing," he said.

And if the AMS is to adequately address the needs of up-and-coming medical professionals, it must also change to mirror the medical profession's current complexion, he said.

"I want to reach out to women and minority doctors, embrace them and bring them into our group as active, participating members who know they have an important contribution to make to the society," he insisted.

Changing Times

While Dr. Stolz plans to actively address the needs of his constituents, he said he also will be available to alleviate any concerns they might have about the ever-changing medical profession.

For instance, he said that he knows many Arkansas physicians are concerned about managed care and how it will continue to affect their practices, but they should rest assured that managed care has probably reached its "peak" in this state.

"We do not have the critical population masses outside

of the Little Rock area to let managed care function the way it wants to function. We are a very rural state, and we don't have the critical population masses outside of Little Rock and northwest Arkansas that capitation will work in," he explained.

Managed care providers thrive on capitation, the process of paying a physician a fixed rate for services provided per patient per month, Dr. Stolz said. The physician is compensated a lesser amount than he usually charges, forcing the physician to cut costs but somehow continue to provide high-quality services.

"I'm optimistic about the future for Arkansas physicians. I think we will continue to see [preferred provider organizations] and other payers try to get more and more discounted fees for services . . . [but] my opinion is that managed care per se is pretty well peaked in Arkansas," Dr. Stolz said.

He said that he thinks managed care providers will begin concentrating their time and efforts on states they perceive as better money makers — states with larger urban populations, such as New York, California and Texas. In fact, several managed care providers have already left Arkansas, which should help ease Arkansas physicians' minds, he added.

Wearing Many Hats

When asked how he plans to juggle everything on his plate, Dr. Stolz laughed. The busy pathologist said that he'll tackle it all one day at a time and that he hopes he will have time to occasionally get away from the rat race.

His favorite distraction is Arkansas Razorback football and basketball, and he often makes the trek to Fayetteville or Little Rock for a game.

He also enjoys the water, he said. Greers Ferry, where he keeps a boat, is a favorite getaway, and with his wife's recent retirement from Petit Jean Vocational Technical School, the couple visits Captiva, Fla., more. The couple also make visits to Jacksonville, Fla., to visit their son, who is a gate agent for American Airlines.

"Captiva is really a well-kept secret. It's not crowded at all. The beaches are beautiful, and it's amazing the number of fine restaurants that are crowded into that one little area," Dr. Stolz beamed.

But although he enjoys the beach, New York City is his favorite city because of the excitement of something always happening, he said.

In fact, Dr. Stolz admits that he thrives on activity and wouldn't know what to do with himself if he couldn't travel, either for work or play.

"I'm used to continuous travel," he said. "It just comes with the territory." ■

Two of his biggest goals, he says, are addressing the needs of the new physicians who are joining the society's fold and making sure that women and minorities are well represented in the society's ranks.

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Doctors, Hospital Coders Can Partner to Reduce Mistakes

Ramona Witcher, RN — Kenya Harbin, RN — Michael Moody, MD

The Health Care Financing Administration has directed the Arkansas Foundation for Medical Care (AFMC), as well as all Peer Review Organizations (PROs) nationwide, to initiate a Payment Error Prevention Program (PEPP) as part of the PRO sixth scope of work. The goal of PEPP is to reduce hospital inpatient payment errors. The Office of Inspector General (OIG) audit of HCFA's 1996 and 1997 Financial Statements estimated Medicare made more than \$4 billion in incorrect payments in each of those years for inpatient hospital services. These payment errors are primarily a result of providers billing for services that are incorrectly coded, insufficiently documented or medically unnecessary.

Another study by the OIG revealed that poor coding was to blame for only 8% of the errors identified. It also indicated that most of the billing problems resulted from insufficient documentation in the medical record—insufficient documentation on the part of physicians and other clinicians. There is a definite link between physician documentation and a coder's ability to produce accurate, useful data. A lack of physician understanding of the DRG reimbursement system can affect coding also.

A recent survey of Arkansas coders indicated that many of the physicians on their hospital staff were not aware of the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis. DRG payment to hospitals is based on the diagnoses and procedures billed. Identification of the correct principal diagnosis is the most important aspect of coding for accurate DRG reimbursement.

The principal diagnosis is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The selection of the principal

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diagnosis depends on the circumstances of the admission—in other words, why the patient was admitted. The words "after study" are an integral part of this definition. During the course of the hospitalization, the admitting diagnosis (which may be a symptom or ill-defined condition) may change substantially based upon the results of further study. For example, a patient is admitted through the ER with an admitting diagnosis of seizure disorder. During hospitalization, diagnostic tests and studies reveal carcinoma of the brain. Therefore, the principal diagnosis is the carcinoma of the brain, not seizure disorder.

Physicians sometimes specify the most serious problem, or the cause of death, as the principal diagnosis. While this may be the diagnosis that has the greatest impact

on the patient's health, the length of stay and the resource consumption, it may or may not be the principal diagnosis. For example, a patient is admitted for a total abdominal hysterectomy for uterine fibroids. While in the OR holding area she develops chest pain and is found to have had a myocardial infarction. The hysterectomy is canceled and the patient is transferred to ICU. The myocardial infarction is a complication of the admission and should be included as an additional diagnosis, but the principal diagnosis is uterine fibroids.

Selection of the principal diagnosis is not really a coding issue; it is a physician documentation issue. The attending physician should always specifically identify the principal diagnosis on each inpatient hospitalization, and the documentation within the medical record should support

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Individuals should make use of the resources in the UAMS Historical Research Center collection when preparing the paper. The award may be used for travel, housing, resource materials and research or secretarial assistance.

There is no required application form. Applicants should send a proposal (summary) of the paper's topic, a proposed budget and an anticipated completion date to the address given below. **Deadline for applications is May 31**, and the winner will be announced in June.

Send proposals to Edwina Walls Mann, Treasurer, History of Medicine Associates, UAMS Library, 4301 W. Markham St., Slot 586, Little Rock, AR 72205-7199. If you have questions, call 686-6733 or e-mail MannEdwinaWalls@exchange.uams.edu.

that diagnosis as the reason the patient was admitted to the hospital.

The UHDDS definition of principal diagnosis is not the only coding convention that must be taken into consideration when assigning a case to the appropriate DRG. The coding directives in the ICD9-CM Official Guidelines for Coding and Reporting must also be applied. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task.

With today's health care providers being monitored so closely by numerous government agencies, it behooves physicians to partner with the hospital coders in working to reduce the occurrence of payment errors. The following steps can be taken by physicians to help hospitals meet the goals of their compliance plans and avoid situations that might suggest fraud or abuse:

- Become involved in the hospital's compliance program.
- Work with coders to address documentation deficiencies.
- Respond to and answer each coding question.
- Read AFMC's PEPptalk for the latest statewide PEPP projects and related coding information. You can find PEPptalk on the AFMC website at www.afmc.org or in your hospital's medical records department.
- Be willing to serve as a physician liaison to bridge the gap between your peers and coders.
- Make sure you have a thorough understanding of the DRG reimbursement system, including the UHDDS definition of principal diagnosis.
- Provide adequate and complete documentation to support each patient's diagnoses and procedures. ■

Correction

A sentence in "Morbidity and Cost of Vaccine-Preventable Varicella in Previously Healthy Children in Arkansas," (December 1999 issue) should have read: "Fifty of 55 patients were greater than 1 year of age and therefore, eligible to receive the vaccine." Children under 1 year of age are not eligible to receive the vaccine.

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Dr. Caplinger Honored as Hero

MedCamps Founder Earns National Award

By JUDITH M. GALLMAN

An Arkansas physician, Dr. Kelsy J. Caplinger is among five medical doctors who have been singled out for their contributions to their professions.

Dr. Caplinger, 62, a Little Rock pediatric allergist who founded Medical Camps of Arkansas Inc., received a Pride in the Profession Award from the American Medical Association and the Pfizer Medical Humanities Initiative. The five were honored in Miami in March at the AMA's National Leadership Development Conference.

Dr. Caplinger, who practices in the College of Medicine of the University of Arkansas for Medical Sciences, was chosen for his work with MedCamps. The programs allow children with chronic diseases to go to summer camp. Dr. Caplinger also operates a private practice, the Little Rock Allergy and Asthma Clinic, P.A.

"It's a tremendous opportunity to make the camp known and gives additional credibility to the camp program. It brings national recognition to the program," Dr. Caplinger said.

Dr. Caplinger began promoting MedCamps as a volunteer in 1971 when he was operating his asthma and allergy clinic in west Little Rock. He decided to do something extra for his young patients with asthma and came up with the idea of a summer camp. Dr. Caplinger believed the young patients would greatly benefit from a camp experience, which he expected would foster a sense of independence.

The first program, an asthma camp at Camp Aldersgate, consisted of one week of camp with 12 campers. Slowly, other



Dr. Caplinger credits other MedCamp volunteers for his success.

specialized camps were added. Dr. Caplinger recalled how he tapped many a nonprofit agency for help, promising to send children to camp one year if those groups would pick up the tab the following summer. They did.

Today, about 350 campers are expected to attend nine weeks of summer camp at Aldersgate, which also serves economically disadvantaged children. Since 1971, more than 6,000 6-16-year-olds have attended the specialized camps, which allow them to interact with children who suffer from the same diseases.

"Many of these kids are the only person in whole school districts with these conditions. They don't have any other people to talk to or learn from. A lot have never been away from home. It's a big step

toward independence," Dr. Caplinger said.

Specialized programs have been created for children with rheumatoid arthritis, asthma, spina bifida and cerebral palsy. Children are allowed to attend, regardless of whether they can afford the camp. The cost is about \$4,000 per child.

Without financial assistance, these children might not ever have a chance to go swimming, float in a canoe or sit around a campfire, Dr. Caplinger said. At the same time, families of these children earn a well deserved break from the time-consuming, intensive care of the disabled child.

Because of Dr. Caplinger's involvement, 12 health agencies and groups — from Arkansas Easter Seals and the American Lung Association to the Arthritis Foundation and Arkansas Epilepsy Society — have formed relation-

ships to act as camp sponsors. MedCamps also are a nonprofit project of the Arkansas chapter of the American Academy of Pediatrics. Over the years, about \$300,000 has been raised for improvements to Camp Aldersgate, including renovating the swimming pool, the bath house and other physical structures.

Dr. Caplinger is modest about his contributions to MedCamps, calling the camp counselors "the unsung heroes." He also praises volunteers, other assisting physicians and health agencies for assisting with MedCamps.

The Pride in the Profession Award, established in 1999, recognizes physicians "whose actions have overcome the challenge of today's changing health care climate and brought healing and hope to people of

all ages and walks of life," according to the American Medical Association.

"While we often hear of those who so nobly push the frontiers of science, oftentimes, true stories of greatness lie with those who labor tirelessly in service to their patients," said AMA Trustee Yank D. Coble, MD. "These are the physicians who go the extra mile — who enrich their patients, their colleagues and the nation by their devotion to the practice of medicine."

"The patient-physician relationship is, has been, and must always remain at the heart of the American health care system. These doctors represent the heart of American medicine," said Dr. Mike Magee, director of the Pfizer Medical Humanities Initiative.

The other honorees were: Dr. Isabel Pino, a pediatrician from Barboursville, W.Va.; Dr. William P. Magee Jr, a plastic surgeon from Imperial, Mo.; Dr. Balazs Imre Bodai, a general surgeon from Sacramento, Calif.; and Dr. Donna E. Sweet, an internist from Wichita, Kan.

Dr. Pino, medical director of West Virginia Children's Hospital and an assistant professor at Marshall University School of Medicine in Long Island, was

recognized for her work with the Children's Fund, which has established a staff and van to serve eight sites in four Appalachian counties.

Dr. Magee and his wife, Kathy, founded Operation Smile, which provides reconstructive surgery and related health care to indigent children.

Dr. Bodai is president of Cure Breast Cancer Inc., a nonprofit group, and chief of surgery for the Sacramento Kaiser Permanente Medical Center. He was honored for his work on behalf of breast cancer, particularly the Breast Cancer Research Stamp.

Dr. Sweet, a professor of Medicine at the University of Kansas School of Medicine-Wichita and director and principal investigator of the Kansas AIDS Education and Training Center, was honored for her care and leadership of patients with HIV and AIDs.

"It was a tremendous honor to be recognized in that way and to see the other nominees and all the things they were doing," Dr. Caplinger said, modestly downplaying how his contributions compared to those of his colleagues. "It was emotional and moving."

Dr. Caplinger is no stranger to honors: He received the President's Volunteer Action Award from then-President Ronald Reagan in 1985; the *Arkansas Democrat* named him Man of the Year in 1979; and he was the recipient of the Arkansas Governor's Award as the Outstanding Volunteer in Arkansas in 1976. He also was the UA College of Medicine's Distinguished Alumnus Award recipient in 1984 as well as Hendrix College's Distinguished Alumnus in 1985.

Dr. Caplinger was born in Hope. He attended UAMS, where he graduated with honors. He also completed an internship in mixed medicine and pediatrics and a residency in pediatrics at UAMS. He also held a fellowship in pediatric allergy at UAMS.

He is certified by the American Board of Pediatrics, the American Board of Pediatrics Subboard of Allergy and the American Board of Allergy and Immunology.

Dr. Caplinger and his wife, Marcia, have five children. Dr. Caplinger has been active in numerous professional societies, civic groups and church activities, and he is the author of many scientific articles. He has been a member of AMS since 1973. ■

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Exercise Best Judgement to Avoid Suits

J. KELLEY AVERY, MD

The surgeon recommended — but did not document — continuing to watch the lesion since it had already shown some resorption. This approach did not satisfy the mother, and on her insistence, laser surgery was scheduled.

An 8-month-old white child had a hemangioma involving the right hand in a glove-like conformation that had been present since birth. The mother, who was a nurse, was understandably very concerned. At about 1 month of age, the baby was seen by a reputable dermatologist, who evaluated the lesion by ultrasound and found the lesion to consist of both capillaries and venules.

In a letter to the referring pediatrician he states, "The capillary component will resorb spontaneously over the next few years. I don't feel any therapy is warranted at this time." On re-examination at 2 months of age the lesion appeared to be spreading slowly up the arm. No therapy was recommended.

Three weeks later a small area appeared in the crease of the wrist on the dorsal side that was open, with some slight drainage and redness. Analgesic cream and antibiotics were prescribed, and a month later a note in the physician's chart stated, "Some definite decrease of hematoma — much lighter." The antibiotic (Bactrim) was continued, and cleaning with hydrogen peroxide was prescribed.

In a letter to the pediatrician: "There has been considerable resorption of the massive hematoma. During resorption of the hemangiomatous tissue, the blood supply to the surface is frequently compromised resulting in cutaneous ulceration. I have been teaching the mother skin care while treating the patient with a combination of topical antibiotics, analgesics and high-potency anti-inflammatory agents. Patient has tolerated this therapy well with good resolution of the ulcer."

Three months later sonography of the hand was reported: "Multiple easily compressible vessels in lesion in right hand. These are all consistent with venous structures, and I do not identify any arteries within the lesion itself."

The mother was not at all satisfied with the "wait-and-see" approach and requested referral to a pediatric surgeon known to be skilled in the use of the laser technology. The surgeon recommended — but did not document — continuing to watch the lesion since it had

already shown some resorption. This approach did not satisfy the mother, and on her insistence, laser surgery was scheduled.

Nowhere in the surgeon's notes does he refer to the mother's attitude toward treatment of her child. There was no discussion of the planned surgery with the mother that pointed out the risks and benefits of the procedure documented in the medical record. It seemed informed consent was assumed.

The YAG laser was used on the dorsal surface of the lesion only, since the hemangioma was circumferential. No difficulties were encountered with the surgery. Ten days after the surgery, the baby was brought back to the surgeon who, along with his residents, examined her. The resident's note states, "Parents were concerned with the darkened eschar. No cellulitis was present. Bactroban (an antibiotic cream) and an antibiotic were prescribed."

A week later the patient was admitted to the hospital for intravenous antibiotics, whirlpool debridement and further evaluation because of obvious infection of the eschar. The admission note states, "She will probably need a skin graft." The discharge summary states, "During hospital course consistently ran fever 102°F and 104°F. Blood cultures revealed no growth. Tissue cultures revealed coagulase-negative staphylococcus aureus. Wound improved with most of eschar removed. Being discharged on oral antibiotics she received in hospital."

The eschar and the infection resulted in the exposure of some of the tendons on the dorsal surface of the wrist and hand, requiring the intervention of a plastic surgeon. Multiple reconstructive procedures followed, including tendon lengthening surgery. Repeatedly, the surgical approach to some contractures in the hand was necessary. On one occasion, the patient was sent to a noted hand surgeon in Louisville, Ky., for examination and opinion. She was told that there had been some radiation damage to some of the bones in the hand and growth would be affected. Functionally, the child has a fairly good

right hand, but cosmetically the outcome is far from satisfactory. She is left handed, but her mother states that the use of the right hand is compromised significantly in the child's normal daily activities.

A lawsuit was filed when the patient was about 4 years old charging the surgeon with negligence because he was not qualified to do the surgery, using the wrong type of laser, lack of informed consent and negligent performance of the procedure. A large six-figure settlement was necessary to end this case.

Loss Prevention Comments

This was indeed a case where two strong-willed professionals were pitted against each other. The nurse mother was a highly trained professional who taught in nursing school, worked as the director of a special care unit in a large tertiary hospital and wanted the best care for her daughter. The physician was a highly trained surgeon and a teacher in a large academic institution. He had become a recognized authority in the use of the laser in surgery and seemed to have been maneuvered into doing definitive surgery after he had counseled the mother to wait. It is obvious from the record that the dermatologist, who documented on at least two occasions that in time much of the hemangioma would resolve, was pressured by events and the mother's insistence to consult the surgeon. He even documented that some of the lesion was resolving at the time the referral occurred.

The development of the superficial skin erosion and infection seemed to indicate to the mother that the course being followed was not the right one. The defendant surgeon stated in his deposition that he had counseled that the best course was to defer definitive treatment for two or three years. The mother was not happy with this approach and even suggested that she wanted the laser surgery for her daughter.

After the surgery when complications developed, the mother thought the surgeon to be inattentive to her daughter. According to the record, the attending physician would make rounds on his patient, make some comment to the mother and then leave the room for his junior associates to deal with postoperative questions, treatments and explanations. One incident that the mother would describe later as typical was on an unscheduled visit to the doctor's office because of the advance of the infection when the child was seen by a junior associate who said that the patient should be admitted to the hospital for intravenous antibiotics, only to have the surgeon, who appeared annoyed, cancel the plans for admission and leave the room without addressing the mother. Five days later the mother phoned the doctor's office to be seen that day and when asked to come in the next day "begged" that he meet them in the emergency department. He came to the emergency department, looked at his patient and said, "It doesn't look as bad as I thought it would," whereupon he left the room, and his junior assistant processed the admission. By this time, the mother, according to her own statement, was thoroughly frustrated and angry.

In the investigation subsequent to the lawsuit, the most frequent comment was that the lesion should not have been treated definitively until much later, after the resolution of the capillary portion of the hemangioma had occurred and the child had grown in size. Other experts commented that the deep damage done to the skin by the surgery may have been responsible for creating the favorable site for the staphylococcus aureus infection.

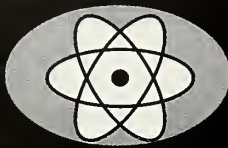
Jousting played a part in this mother's deep resentment of the surgeon. A resident seemed to go out of his way to criticize the surgeon as to his uncaring and unfeeling attitude.

The depth of this doctor's criticism led the mother to report the surgeon to the State Board of Medical Examiners in addition to the malpractice suit that had been filed against him.

The anger brought on by what the mother interpreted as uncaring behavior by the physician, the bad result in the development of the deep eschar and infection and the years of restorative care required to achieve a functional hand, resulted in circumstances that brought about the decision that the large six-figure settlement was in the physician's best interest.

In this situation there should have been a pointed effort on the part of the physician to understand the attitude of the nurse, and, therefore, to take more time to address her concerns all along the way. It is never a good idea for the physician to allow the pressure of patient or family to push him or her into a treatment plan that is not clinically appropriate. It would appear from the record that this lesion, as unhappy as it made everybody, should have been watched for a much longer period. When the decision was made to do the laser surgery, the physician should have been very careful to explain just what they were getting into, the negatives, including infection, the alternative of waiting for maximum resorption of the lesion and truly having an informed consent by the parents. As physicians, we are trained to exercise our best judgment in the care of our patients. In this case, that was not done, and a long painful legal experience developed for both of the professionals involved. ■

The case of the month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Co., Brentwood, Tenn. This article appeared in the March 2000 issue of Tennessee Medicine. It is reprinted with permission.



Diagnosis of Ovarian Vein Thrombosis

AUTHORS:

CHERYL L. GREEN, MD
PHILLIP ALSTON, MD

EDITOR

STEVEN R. NOKES, MD

History:

A 34-year-old woman presented with lower abdominal pain and tenderness, flank pain and spiking fever two weeks after caesarean section. A CT of the abdomen and pelvis was performed.

Diagnosis:

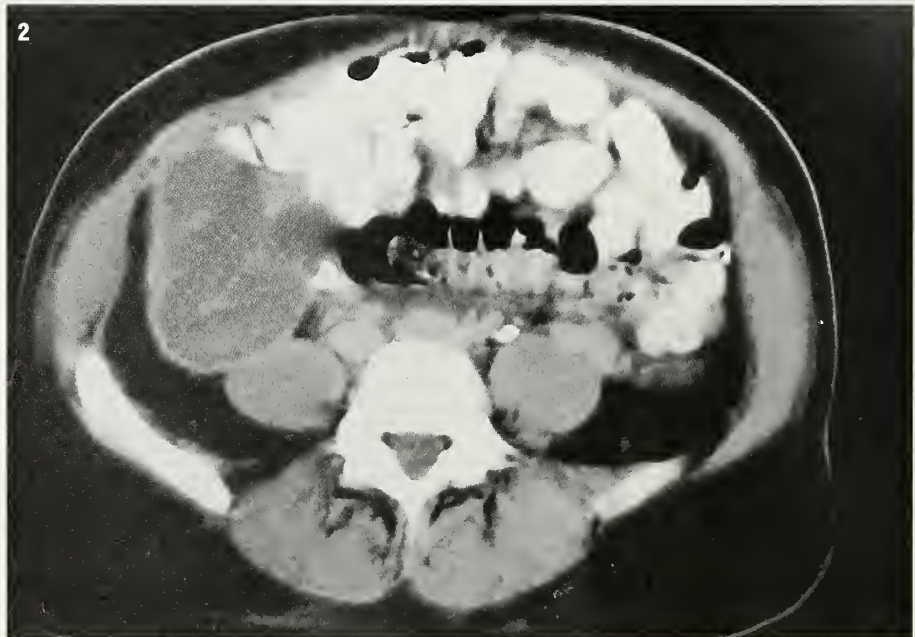
Ovarian vein thrombosis

Findings:

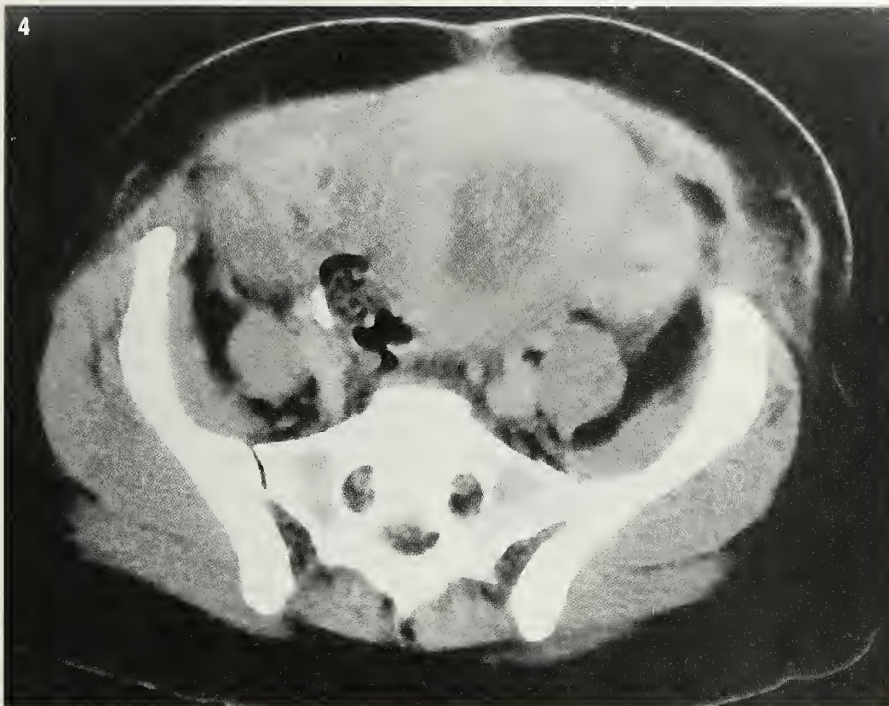
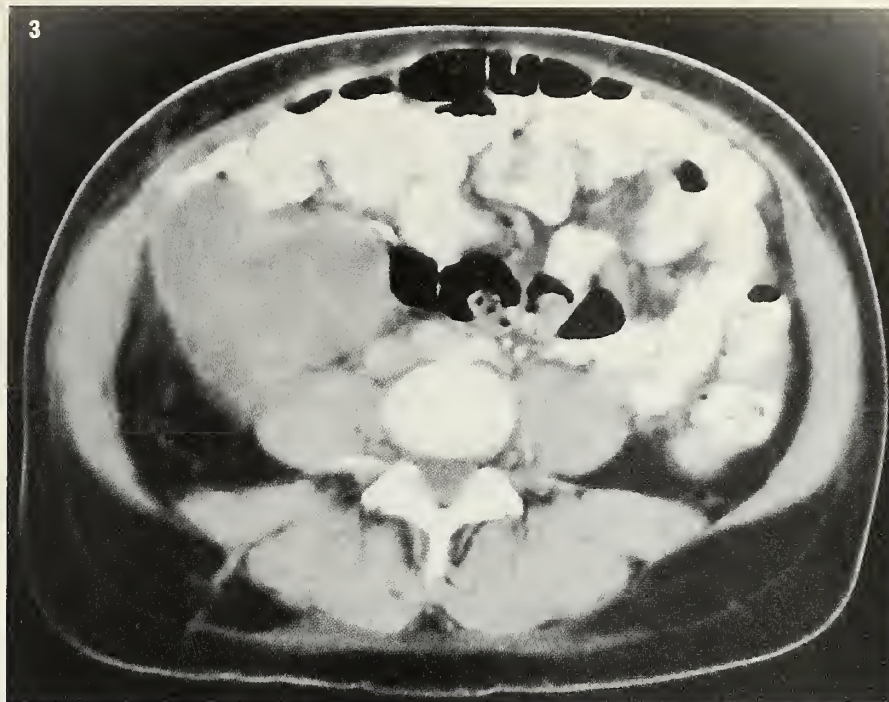
CT shows an enlarged thrombosed right ovarian vein as a tubular structure, which extends from the level of the uterus into the inferior vena cava just above the level of the right renal vein (Fig. 2 and Fig. 3). There is supra-renal extension of thrombus into the IVC (Fig. 1).

Discussion:

Before the advent of cross-sectional imaging methods, OVT was difficult to diagnose. Most cases



Figures 1-4. CT scan of the abdomen and pelvis.



were diagnosed at surgery. Diagnosis of OVT using CT was first reported in 1981. Since then, the CT, sonographic and MR imaging findings of this entity have been well described, and these methods have been shown to be reliable for detecting OVT.

Characteristic findings on contrast-enhanced CT scans include dilatation of the ovarian vein: a low-attenuation center in the vein, representing thrombus; and contrast enhancement of the walls of the vein.

The thrombosed vein is seen as a tubular structure originating in the region of the adnexa and extending cephalad in the retroperitoneal region to the level of the renal veins. On sonography, the thrombosed vein appears as an anechoic to hypoechoic mass extending superiorly from the adnexa, with absence of flow on Doppler interrogation.

Sonographic visualization is frequently limited by overlying bowel gas. MR imaging findings are gener-

ally those of a subacute clot, with high signal intensity within the thrombosed vein.

In the postpartum period, three factors contribute to the pathogenesis of OVT: increased levels of circulating clotting factors, stasis of blood flow and damage to the wall of the vein. OVT has a 90% right-sided preponderance. The left ovarian vein is generally spared because of the tendency for retrograde blood flow to that side in the postpartum period. The right ovarian vein also is the longer of the two and contains multiple incompetent valves, which may act as sites of stasis or niduses for thrombosis.

Even with the availability of CT and sonography, diagnosis may be delayed because the syndrome is an accurate mimic of more common conditions such as endometritis, appendicitis and pyelonephritis, and clinical suspicion may be misdirected. Complications of OVT include septic pulmonary embolism and ureteral obstruction. Treatment usually involves antibiotics and anticoagulation, with surgery reserved for failure of medical treatment. ■

References:

1. Munsick RA. Gillanders LA. A review of the syndrome of puerperal ovarian vein thrombophlebitis. *Obstet Gynecol Surv* 1981; 36:57-66.
2. Shaffer PB. Johnson JC. Bryan D. Fabri PH. Diagnosis of ovarian vein thrombophlebitis by computed tomography. *J Comput Assist Tomogr* 1981;5:436-439.
3. Dunnihoo DR. Gallaspy JW, Wise RB, Otterson WN. Postpartum ovarian vein thrombophlebitis: a review. *Obstet Gynecol Surv* 1991;46: 415-427.
4. Jacoby WT, Cohan RH, Baker ME, Leder RA, Nadel SN, Dunnick NR. Ovarian vein thrombosis in oncology patients: CT detection and clinical significance. *AJR* 1990;155:291-294.

Dr. Nokes and Dr. Green are with Radiology Consultants in Little Rock. Dr. Alston is in private practice in Little Rock.

The Use of Instant Medical History in a Rural Clinic

Case Study of the Use of Computers in an Arkansas Physician's Office

BY BARRY PIERCE, MS

This study evaluated the acceptance of using computers to take a medical history by rural Arkansas patients. Sex, age, race, education, previous computer experience and owning a computer were used as variables. Patients were asked a series of questions to rate their comfort level with using a computer to take their medical history. Comfort ratings ranged from 30 to 45, with a mean of 36.8 (SEM=0.67). Neither sex, race, age, education, owning a personal computer, nor prior computer experience had a significant effect on the comfort rating. This study helps alleviate one of the concerns — patient acceptance — about the increasing use of computers in practicing medicine.

Introduction

It has long been recognized that computers could aid in the delivery of health care. Warner Slack used computers to screen patients more than 25 years ago with the forecast, "computer interviewing holds the promise of directly, consistently and accurately gathering the medical history."^{1,2} The primitive software and massive hardware required for computers at that time limited their use to only a few tasks.

Most of the anxiety and fear associated with the use of computers is disappearing. Medical records have been computerized, reference material digitized, and educational resources automated. Physicians are using computers to help with diagnoses, monitor patient progress and to select and keep track of prescriptions. Recent studies have shown that with the advancement of computer technology over the last several years and its wide spread use in everyday life, it is now practical to use this as an added tool in gathering the medical history.²⁻⁷

The use of patient-driven interview software to generate the subjective medical history can help speed diagnosis. Many believe that this computer revolution in medicine will help improve patient care by helping to manage the mountain of patient data associated with the practice of medicine today.^{2-4,7,8} Others are concerned that the use of computers in the exam room may actually hinder patient care by interfering with the doctor/patient relationship.⁹⁻¹¹

Francois Gremy, MD, professor of public health at the University of Montpellier in France, put the use of this "high-tech" tool into perspective in his presentation to the 1993 Symposium on Clinical Applications in Medical Care. "Al-

though informatics can be helpful in the treatment of disease, it is useless in the treatment of the patient," Dr. Gremy said. "But it can alleviate [our] analytic, intellectual work, save part of our time and make us more available to meet the patient's needs and wishes. So the most inhuman science may be a contributor to the reintroduction of some humanity into our profession."⁵

In taking a history of a patient's illness, all physicians include a review of systems in an initial evaluation. Dr. Allen Wenner, a practicing family physician, computer consultant and teacher at the University of South Carolina in Columbia, said, "With any illness, a limited review of the organ system involved is done. Computerization of a review of systems is appropriate because the process is repetitive, time-consuming and monotonous. The computer's strength lies in its ability to quickly and accurately do tedious tasks as many times as needed." By reducing time consuming history that is essential to diagnosis, the physician can concentrate the entire interview on treating the patient. Also, documentation is clear that appropriate data was gathered from the patient. Incorporation of the data into an electronic medical record system saves significant transcription costs, eliminates substantial dictation time by the physician and assures medical record



Computers can help speed diagnosis.

completeness.^{6,8}

With the ever-increasing use of computer in the practice of medicine, it is important that we consider the impact this new presence will have on patients. This survey concentrates on the use of computers to generate the subjective history of pre-

senting complaints of outpatients in a rural Arkansas clinic. The purpose of this study is to determine what patients think about using a computer to help communicate their problems more effectively to their physicians. Considering this statement, we will look at the practical use of computers in a rural Arkansas primary care clinic by answering the following question: Will a rural Arkansas clinic patient accept the use of a computer in obtaining a medical history in a walk-in clinic?

Methods

Instant medical history software was used in this survey to evaluate patients' feelings about using computers to take their medical history. The software is patient driven and uses a branching logic to interview and record a full medical history. It asks questions in a simple multiple choice format. These questions are the same type that the physician would normally ask in a live patient interview. The patient answers the questions by touching the first letter of the answer on the keyboard. The branching logic technology uses the patient's responses to each question to initiate additional questions that become more specific. The software then translates the answers into medical terminology for review. The doctor can then look at the data before seeing the patient and have a diagnosis in mind. All the pertinent negatives are done.

Interviewing Software Sample Questions and Output:

Questions to Patient:

- Do you have a fever?
- Was your fever higher than 102°F?
- Did you have shaking chills?
- Do you have a sore throat?
- Do you have a runny nose?
- Is the discharge from your nose green?
- Do you have a cough?
- When you cough, do you cough up any phlegm or sputum?
- Is the color of the sputum green?
- Do you cough up more than a teacup full of sputum within 24 hours?
- Are you short of breath?
- Does your chest hurt when you take a deep breath?

Output to Physician:

Subjective: Patient has fever, >102, chills, pharyngalgia, purulent rhinorrhea, cough, productive greenish sputum, >2 oz sputum 24 hrs, dyspnea, pleuritic chest pain; SOB, Patient denies otalgia, seasonal rhinorrhea, headache, symptoms >3 days, tobacco use.⁸

The program also can be used for other things such as general health screenings and reminders. Using computers during consultation has been shown to improve immunization rates by 8%-18% and other preventative tasks by up to

Study of Computerized Medical History Taking in a Rural Arkansas Clinic Using Instant Medical History

The Family Practice Clinic is studying new technology to improve patient care. We want to know what our patients think about using a computer to give medical information to their doctor. We will not keep the information you give us in the computer but will print it out and attach it to your record for your doctor to use today here in clinic. We will keep information only on your thoughts and opinions about dealing with this new way of doing things.

Male	Female
Age	
20 under	51-60
21-30	61-70
31-40	70
41-50	71+
Education (in years of schooling)	
1-4	14
4-8	15
9-12	16
13	17 or more
Ethnic group	
African American	Asian
Caucasian	Mixed
Other	
ZIP CODE where you live _____	
Is English your first (primary) language? Yes No	
State in which you were born AR Other _____	
Country in which you were born USA Other _____	
Agrees to participate _____	
Declines participation _____ Why _____	
Have you been to this clinic before? Yes No	
Have you used a personal computer before? Yes No	
Do you own a personal computer? Yes No	
Have you ever given a medical history using a computer? Yes No	
The idea of having my medical information on a computer bothers me	
1. Not at all	2. Somewhat
3. Yes, quite a bit	4. Very much so
Are you comfortable with computers?	
1. Not at all	2. Somewhat
3. Yes, quite a bit	4. Very much so
Is using the computer to gather medical information before your visit a good idea?	
1. Not at all	2. Somewhat
3. Yes	4. Yes, and excellent idea
Do you think you will be comfortable answering personal questions on a computer?	
1. No	2. Somewhat uncomfortable
3. Comfortable	4. Very comfortable

Appendix 1

50%.^{7,11} For example, a patient who drinks alcohol will automatically be asked the CAGE questionnaire. Then all of this patient's data can be directly transferred into their electronic record, decreasing filing and dictation and improving documentation.

This particular software was chosen because of its ease of use and availability. It is a very powerful interviewing tool. However, this study is more focused on whether patients will accept the use of computers (with IMH or similar software) to help in collecting and relaying their medical history information to their physician.

Setting

Stuttgart Medical Clinic is a large primary care clinic that schedules patients by appointment from 8 a.m.-5 p.m. Monday-Friday. The clinic is staffed by nurses, two nurse practitioners and six physicians. The clinic sees approximately 400 patients per week on average with patients ranging from prenatal to geriatric.

Procedure

Data Gathering: Patients are logged in to the clinic at

the front desk and called in order. Patients over the age of 18 years were randomly sampled and invited to participate and then asked to complete a form (Appendix 1) on how they feel about computers in their medical care. Patients were asked to give their name, age, education, ethnic group, zip code, primary language, state and country in which they were born. They were then asked if they would use a computer to give their medical history for that day. Those who declined to participate were to be asked why they declined; those that did participate were asked how they feel about using a computer to give a medical history. They were then asked to name a single organ system (skeletal, nervous, lungs) that was bothering them. Directions for using the computer were on the computer screen. The number of questions asked varied based upon the answers given by the patient. The information was printed and attached to their charts for the day.

Patients were then asked questions after using the computer about their feelings and ideas about the experience. The answers to this second set of questions were then totaled to yield an overall comfort rating. The data was then analyzed for statistical significance using SigmaStat™. Age and education were collapsed to form groups for analysis. Sex, race, previous computer experience and computer ownership also were used as variables.

Results

Twenty-five patients were selected and asked to participate in the survey. All 25 agreed to participate. The effects of variables (e.g., sex, race) on comfort rating was examined. Comfort ratings ranged from 30 to 45, with a mean of 36.8 (SEM=0.67).

Of those enrolled in the survey, 60% were female and 40% were male, compared to about 62% and 38% respectively for the overall clinic population for June 1998. Age data was collapsed to form two groups, those 50 years of age and older and those younger than 50 years of age. Education also was collapsed to form two groups for comparison. Education group one included persons with 12 or

less years of education, and group two included patients with greater than 12 years of education. All 25 of the participants had been to the clinic before, and none had ever used a computer to give a medical history. Slightly less than half (11) of those in the survey had never used a computer before, with less than a third (28%) having their own computer.

Neither sex nor race had a significant effect on the comfort rating with $p=0.760$ and $p=0.761$ respectively. Age and education were crosstabulated and as one might expect, the patients in age group one (50 years or older) were more likely to have a greater than high school education (education group two) than age group two (less than 50 years), which may explain the similarities in the mean scores between the two variables. However, neither had a significant effect on the comfort rating with p values of 0.529 for age and 0.588 for education level. Prior computer experience also did not increase the patients comfort level (based on rating score) with the computerized medical history, nor did owning a personal computer.

Discussion

Although this was only a small study with a limited sample size, none of the variables studied had a significant effect on the comfort rating score. Some significant effect may be seen with a larger sample size, which was not possible with this study due to personnel and time constraints. Further studies should include a larger sample size and a comparison to urban medical clinics. A similar study, looking at comfort ratings of indigent patients, is being conducted at New Orleans' Charity Hospital by Dr. John Dugaw in the department of family medicine.

The patients in this survey all seemed to be comfortable (Mean Comfort Rating=36.8) with using the IMH software, regardless of their sex, age, race, education or computer experience. This shows that even in rural areas, people have accepted computers into their daily lives. This acceptance of using the IMH software (and similar programs) makes it easier for physicians to make the change themselves to a more computer-based office. By doing

so, they can increase their efficiency and possibly even be able to spend more quality time with patients. It also has the benefit of the patient seeing that their physician is familiar with the latest technology in caring for his/her patients. Medicine is such an information intensive profession, it makes sense that the better you can manage patient information, the better you will be able to care for your patients.

As stated earlier, computers in the physicians' office can help in many other ways. In an article, "Computers in Family Practice," Randall Oates, MD, a practicing family physician in Springdale, Ark., and founder of DOCS Inc., discussed other uses for computers. He describes their use in reviewing the latest diagnostic information. Also, he pointed out how computers can help eliminate problems with drug interactions.⁶

There is now a growing popularity towards the use of handheld and palmtop computers in the medical field. These smaller machines overcome many of the problems incurred with trying to use laptop computers during the patient exam. Their uses range from a method to track patients to keeping schedules and reference material easily accessible. Since billing codes can be kept with the physician at all times, he/she can enter this information into the patient's file while visiting with the patient, saving the time (and expense) of having someone to code procedures later.

One of the biggest obstacles to using this new technology is the learning curve on the physicians' part. Computer training is offered only to a small extent, if at all, in most medical schools. Some studies show that computer based clinical programs are not as widespread as we might think, for this very reason.^{6,7} This lack of training also was identified as a reason for lack of effectiveness of some computer-based clinical support systems.¹¹ Many schools are starting to make computer training a prerequisite for entering medical school.¹² And more and more hospitals are going to electronic medical records.

As we move up the learning curve and technology becomes more user-friendly, we will see more and more physicians entering the computer age. Many patients

are already more computer savvy than their doctors are. As this study showed, even patients in rural Arkansas are comfortable with computers in the exam room. It is time physicians embrace this new technology and use it to its full potential. Once this happens, physicians and their patients will begin to benefit from computer assisted medical practice.

Acknowledgment

I would like to thank Dr. Allen Wenner and Dr. John Dugaw without whom this project would not have been possible. ■

References:

1. Elson, R.B., and D.P. Connelly: Computerized patient records in primary care: their role in mediating guideline-driven physician behavior change. *Arch Fam Med*. 1995; 4:698-705.
2. Haessler et al. United States Patent 4,130,881. "System and technique for automated medical history taking" Filed January 28, 1974;

- Granted December 19, 1978.
3. Lamberg, L.: Computers enter mainstream psychiatry. *JAMA* 278: 799-801 (1997).
4. Austin, S.M., E.A. Balas, J.A. Mitchell, and B.G. Ewigman: Effect of physician reminders on preventive care: meta-analysis of randomized clinical trials. *Proc Annu Symp Comput Applications Med Care*. 1994:121-124.
5. Francois Gremy, Keynote Address; Society Computer Applications in Medical Care, Washington Sheraton; Washington, D.C.; (November 2, 1993).
6. American Academy of Family Physicians, "Computers and family medicine" FP Report, (July 1996).
7. Johnston, M.E., K.B. Langton, R.B. Haynes, and A. Mathieu: Effects of computer-based clinical decision support systems on clinical performance and patient outcome: A critical appraisal of research. *Annals of Internal Medicine*. 120(2): 135-142. (January 15, 1994).
8. Primetime Medical Software, Inc.: Instant Medical History, Manual for version 1.6, West Columbia, S.C. (1994).
9. Woodward, B.: The computer-based patient record and confidentiality. *The New England Journal of Medicine*. 333(21): 1419-1422. (1995).
10. Rethans, J.J., P. Hoppener, G. Wolfs, and J. Diederiks: Do personal computers make doctors less personal?
11. Sullivan, F., and E. Mitchell: Has general practitioner computing made a difference to patient care? A systematic review of published reports. *BMJ*. 311 (7009): 848-852. (1995).
12. Medical informatics and computer applications. Recommended core educational guidelines for family practice residents. Reprint no. 288. Kansas City, Mo.: *American Academy of Family Physicians*, 1996. (Revised 1997).

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HONORED

UAMS Students, Resident Win National Award

Two medical students and a resident at the University of Arkansas for Medical Sciences were chosen as part of 50 outstanding young medical professionals honored by the American Medical Association Foundation at the AMA's annual National Leadership Development Conference in Miami.

Erik Shultz, a third year medical student; **Sandra Marchese Johnson, MD**, a dermatology resident; and **Charles Caldwell Mashek**, a second year medical student, were honored with the AMA Foundation's Leadership Awards.

Twenty-five medical students and 25 resident and fellow physicians were honored for their exceptional leadership among their peers and their achievements in non-clinical community activities.

Shultz, outgoing president of the Medical Student Section of the Arkansas Medical Society, was winner of the AMA Alliance Scholarship in 1999 and a NASA Space Grant Consortium Award winner in 1994. He was named one of the Outstanding Young Men in America in 1998.

Johnson, chairman of the Resident and Fellows Committee of the American Academy of Dermatology, also serves on the AAD's board of directors and on several local medical committees.

Mashek is vice president of the Medical Student Section of the AMS. Before medical

school, he was a commissioned officer in the Arkansas Army National Guard, where he has served for more than 10 years.

Physicians Receive Award from AMA

Each month the American Medical Association presents the Physician's Recognition Award to those who have completed acceptable programs of continuing education.

PRA recipients in February included **Dr. James T. Henry** of Little Rock; **Dr. Dale E. Johnston** of Little Rock; **Dr. Gregory A. Kendrick** of Conway; **Dr. Edward Loebl** of Little Rock; **Dr. Gail Ann McCracken** of Little Rock; **Dr. Lisa Kay McGraw** of Rogers; **Dr. Angela Kay Nutt** of Little Rock; **Dr. Scot Joseph Snodgrass** of Jonesboro; and **Dr. Hoy Barksdale Speer** of Stuttgart.

Medical Student Honored for Recruitment

At a recent meeting of the Medical Student Section of the AMS, **April Davidson**, secretary/treasurer for 1999-2000, was recognized for her recruitment of new members. Davidson's efforts resulted in a 95 percent recruitment of the entering freshman class. This also was recognized at the Regional AMS-MSS meeting in New Orleans last fall as being significantly above the average for Region 3 of the AMS-MSS.



New officers for the Medical Student Section of the AMS for 2000: From left to right, Charles Mashek, vice president; Dwight Johnson, president; Heather Diemer, alternate delegate; Matthew Kincade, secretary-treasurer; and Blake Geren, delegate.

ELECTED

New Medical Students Elected AMS Officers

Officers were recently elected for the medical student section of the Arkansas Medical Society. New officers are **Dwight Johnson**, president; **Charles Mashek**, vice president; **Matthew Kincade**, secretary/treasurer; **Blake Geren**, delegate; and **Heather Diemer**, alternate delegate.

Johnson is a sophomore medical student from Scranton who entered medical school after a successful career as an engineer. He is a 1975 graduate of the University of Arkansas and has a master's degree in industrial engineering from the university.

Mashek is from Dardanelle and is a sophomore medical student. Before medical school, he served in the U.S. Army, where he achieved the rank of captain. Mashek graduated from Ouachita Baptist University with a degree in mathematics. He also obtained a master's in business administration from OBU.

Kincade is a freshman medical student from Maumelle. He graduated with a bachelor's degree in political

science from the University of Arkansas.

Diemer, a sophomore medical student, is from Little Rock. She graduated from the University of Arkansas with a bachelor's in biology. She also worked on her master's of science in counseling at Fayetteville.

Geren is a freshman medical student from Harrison. He graduated from the University of Arkansas as a Senior Scholar with a bachelor's in microbiology.

Dr. Proffitt Named Hospital Chief of Staff

Danny L. Proffitt, MD, a family practitioner in Fayetteville, was elected to a two-year term as chief of staff of Washington Regional Medical Center in Fayetteville.

He has been a full-time faculty member and assistant professor at the UAMS AHEC-NW Family Practice Residency Program in Fayetteville/Springdale since 1981. He has served as vice-chief of staff at Washington Regional for two years.

Dr. Proffitt attended Arkansas State University from 1970-1974 and obtained a bachelor's in zoology. He obtained a medical degree from

UAMS in 1978 and completed residency education in family medicine.

He is married to Anita Kirk Proffitt, and they have three sons, twins David and John, 15, and Andrew, 12.

Washington Regional is a 294-bed acute care medical center with more than 250 staff physicians.

OBITUARIES

Gastor Bernard Owens, MD

Dr. Gastor Bernard Owens of Morrilton died in Enid, Okla., March 2, 2000. He was 83.

Dr. Owens was born June 30, 1916, in Little Rock. He graduated from Little Rock High School and went on to get his bachelor's degree from Ouachita Baptist University in Arkadelphia. Dr. Owens graduated from the University of Arkansas for Medical Sciences with a medical degree.

He had a private practice in Morrilton for 35 years.

Survivors include his wife, Martha Owens; daughters Rosemary Brenner of Harrisburg, Va., and Julia Dennis of Memphis, Tenn.; son Ozzie Crawford and daughter-in-law Brenda, of Enid, Okla.; five grandchildren; two great-grandchildren; two brothers; and a sister.

Kathleen Thomsen Hall, MD

Dr. Kathleen Thomsen Hall, 44, died in Shrewsbury, Mass., March 6, 2000.

Dr. Hall was a prominent forensic psychiatrist who practiced in Little Rock until moving in 1997.

Dr. Hall was living in Shrewsbury, Mass., where she recently completed a psychiatry fellowship at the University of Massachusetts Medical Center. Before moving to Massachusetts, Dr. Hall was in private practice in Little Rock for 12 years and did patient work at St. Vincent Infirmary Medical Center and Baptist Medical Center. She completed her psychiatric resi-

dency at University Hospital, where she was chief resident, in 1983. She received her medical degree from Loma Linda University Medical School in Loma Linda, Calif.

Dr. Hall also served as legislative representative and committee chairman for the Arkansas Psychiatric Society. In 1996, she initiated and became chairman of the Arkansas Mental Health Parity Coalition, which sought to achieve equal health-care benefits for patients with mental disorders. She received the Arkansas Psychiatric Society's Payton Kolb Award and the Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill for her efforts.

Survivors include her daughter, Valerie Noel Hall; mother Grace Thomsen; and sister Christina Thomsen. She is the widow of Jon Hall, a clinical psychologist.

Joy Lucretia Deere, MD

Dr. Joy Lucretia Deere, 65, of El Dorado, died Oct. 10, 1999, at the Medical Center of South Arkansas in El Dorado.

Born in Dallas to Albert T. and Jimmie Carter Deere, Dr. Deere graduated from medical school in 1959. She is buried at Laurel Land Memorial Park in Dallas.

Thomas H. Hickey, MD

Dr. Thomas H. Hickey, 75, of Morrilton, died Feb. 17, 2000.

A descendent of a pioneer family, Dr. Hickey was born in London in Pope County. He served three years in the U.S. Army during World War II, earning the Bronze Star Medal.

Dr. Hickey graduated from the Arkansas School of Medicine in Little Rock in 1951. He began his career in Atkins, but then moved to Morrilton in 1952 and practiced medicine there for 47 years.

In addition to serving as mayor of Morrilton for 17 years, Dr. Hickey was a former chief of staff at the Conway County

Hospital — now St. Anthony's Healthcare Center — past president of the Conway County Medical Society and medical director of Morrilton's two nursing homes for 20 years. He had been appointed to the Arkansas Health Services Board by former Gov. Bill Clinton.

Dr. Hickey was preceded in death by his first wife, Ruth Virginia Newton, but is survived by his second wife of 17 years, Hazel J. Hickey.

Ben H. Cheek, MD

Dr. Ben H. Cheek, 76, of Conway, died Feb. 21, 2000.

Born in Florence, S.C., Dr. Cheek was a graduate of the Medical University of South Carolina. He was base physician at Pine Bluff Arsenal before working for the Directorate of Biological Operations there. He retired as medical director for the Jefferson County Comprehensive Care Center in 1989.

Dr. Cheek was honored as College of Charleston Alumnus of the Year in 1990, and he and his wife established the Ben and Frances Cheek Scholarship there.

He is survived by his wife, Frances Tidwell Cheek, one son and daughter-in-law, one step son, one brother, two grandchildren, two step granddaughters and one great-great granddaughter.

Buford Milton Gardner Sr., MD

Dr. Buford Milton Gardner, Sr., 80, of Star City, died Feb. 10 in Little Rock.

He was born April 26, 1919, in Ashley County. Dr. Gardner graduated from Arkansas A&M College in Monticello and received his medical degree from the Arkansas Medical School, now the University of Arkansas for Medical Sciences, in 1942. He began his family prac-

MEMORIAL RESOLUTION

Thomas Dale Alford, MD

Whereas, the members of the Pulaski County Medical Society are sincerely saddened by the recent death of an esteemed colleague, Thomas Dale Alford, MD; and

Whereas, he was a loyal member of this Society for 52 years; and

Whereas, Dr. Alford's patriotism was evidenced by his service as a U.S. Army surgeon during World War II; state commander, American Legion; membership in Veterans of Foreign Wars, and disabled American Veterans Association; and

Whereas, Dr. Alford's concern for the greater community was manifested through his election to the 86th and 87th U.S. Congress as a representative of the state of Arkansas, service on the Little Rock School Board, University of Arkansas at Little Rock Board of Trustees, founding member of St. Mark's Episcopal Church and numerous other civic organizations; and

Whereas, Dr. Alford's life of faith in God and service to others will stand as an enduring example to his fellow men;

Be it therefore resolved:

That, this resolution be adopted and placed in the permanent files of the Society; and

That, a copy be sent to Dr. Alford's family as an expression of our heart-felt sorrow; and

That, a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted Feb. 15, 2000, Board of Directors.

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tice in Star City in 1943. From 1958-1961, he practiced at the Veterans Administration Hospital in Fayetteville. Gardner eventually returned to his practice in Star City and retired in 1980.

He was active in the Lions International and served as district director for the Northwest Arkansas area.

Survivors include his wife, Darline Hickerson Gardner of Star City; four sons, Buford Milton Gardner Jr. of Harrison, John W. Gardner of North Little Rock, Joseph William Gardner of Clinton and David Christian Gardner of Virginia Beach, Va.; daughter Karen Gardner of Lawton, Okla.; two brothers, 11 grandchildren; four step-grandchildren; and eight great-grandchildren. ■

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